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BY

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DEDICATION

To my father, Sookhoo, and
my mother, Narainee, for
their love and support
over many years.

ABSTRACT

The evaluation of treatment methods for alcoholics is becoming increasingly popular. The aim of this study was to evaluate the Alberta Alcohol and Druge Abuse Commission (AADAC) West End Centre treatment program. This is an outpatient 2-week program for substance-abusers which employs group therapy as the prime treatment modality. A sample of alcoholics (N=34) was evaluated on pre- and post-test measures with an interval period of 3 months. Subjects were volunteers.

The research instruments used were 5 questionaires which incoporated, among other questions, 3 scales: the Drinking Related Internal-External Scale (DRIE), the Bradburn Affect-Balance Scale and the Khavari Alcohol Test. A "t" test for correlated means and a Z-test of proportions were used to determine significant post-treatment outcome variables.

The scales have shown to be reliable and valid measures of the outcome variables, namely, control of drinking behaviour, psychological well-being and absolute amount of alcohol consumed. Except for 2 items on the DRIE, subjects improved on outcome measures of the 3 scales.

Useful information has been provided by this study in underscoring the utility of group therapy in treating alcoholics. The study also suggests that more emphasis be placed on such social variables as interpersonal pressure and the influence of external factors or events as

precipitators of drinking behaviour.

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Chapter I

INTRODUCTION

Alcoholism, it seems, has always been a problem for humankind. From pre-historic to the present time, in every culture and civilization, it has existed in one form or another and to varying degrees. Today, despite widespread use of the term, alcoholism is still difficult to define and diagnose precisely because of the many criteria that are used. However, clear definitions and adequate models are necessary if better identification and treatment methods are to be developed. The present chapter will:

(A) give some common definitions of alcoholism;

(B) outline two models of alcoholism;

(C) describe the epidemiology and some consequences of alcohol abuse;

(D) define some frequently used terms; and

(E) focus on the purpose, tasks, significance and limitations of the present study.

A. Definition of alcoholism

Jellinek (1960), the "father of alcoholism" defined the condition as "any use of alcoholic beverages that causes any damage to the individual or to society or both" (p.35). He viewed alcoholism as a disease in which there was a definite pattern of progression in terms of increasing dysfunction. Furthermore, he provided five descriptive patterns of drinking: alpha, beta, gamma, delta and epsilon. However,

Jellinek's concepts were vague and too general and therefore did not provide for adequate diagnosis and treatment of alcoholism.

The World Health Organization (WHO) Expert Committee (1975) has recommended that the term "alcoholism" be abandoned because of the difficulty in defining it. They advocate that it be replaced by the phrase "alcohol-type drug dependence". The WHO definition of this disorder is as follows:

> "Drug dependence of the alcohol type may be said to exist when the consumption of alcohol by an individual exceeds the limits that are accepted by his culture, if he consumes alcohol at times that are deemed inappropiate within that culture, or his intake of alcohol become so great as to injure his health or impair his social relationships" (p. 107).

The third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM III; American Psychiatric Association, 1980) distinguishes detween alcohol dependence (alcoholism)and alcohol abuse. Alcohol abuse is defined as drinking in a manner that results in an alcohol-related disability. The latter is viewed as an impairment in social or occupational functioning because of a problematic drinking pattern that has been present for at least a period of one month.

DSM III defines alcohol dependence as drinking in such a manner that an alcohol-related disability results and, in addition, that significant tolerance or withdrawal develops. Alcohol use that does not result in disability and does not lead to tolerance or withdrawal has no psychiatric

diagnosis.

A comparison of the WHO and the DSM III definition reveals an important difference in emphasis. The World Health Organization relies primarily on cultural criteria to define alcoholism, whereas the American Psychiatric Association emphasizes damage to personal health, and impairment in social and occupational functioning.

The Alberta Alcoholism and Drug Abuse Commission (1983) views alcoholism as "an ongoing inappropriate use of alcohol which causes increasingly more serious problems in a person's physical or mental health, work, family or social life" (p. 1).

The foregoing definitions are based on a binary diagnosis of alcoholism. That is, an individual may be diagnosed as an alcoholic or not as an alcoholic. Such a diagnosis rests upon two current models of alcoholism.

B. Models of Alcoholism

A model of alcoholism is a set of assumptions about the nature of this condition. The two current general models are the unitary or undimensional model and the multivariate or multidimensional model.

According to Albrecht (1973) "a unidimensional model can be understood to be one that attends to only one aspect of a process or it can be viewed as one that focuses upon a single path of a variety of possible paths to a certain outcome" (p.19). This type of model assumes that all

alcoholics follow the same route to eventual alcoholism. Pattison, Sobell and Sobell (1977) outlined the basic tenets of the unitary model :

1. There is a unitary phenomenon that can be identified as alcoholism. Despite variations, there is a distinct entity.
2. Alcoholics or pre-alcoholics are essentially different from non-alcoholics.
3. Alcoholics experience an irresistible physical craving for alcohol, or an overwhelming psychological compulsion to drink.
4. Alcoholics develop a process of loss of control over initiation of drinking and/or inability to stop drinking.
5. Alcoholism is a permanent and irreversible condition.
6. Alcohol is a progressive disease that follows an inexorable development through a series of more or less distinctive phrases.

However, Pattison et al (1977) found this model inadequate. Each of the 6 above assumptions about alcoholism was not adequately supported by scientific data. They proposed the reformulated, multivariate model which basically assumes that different types of alcoholism exist and that the paths to eventual alcoholism can vary from individual to individual. The following are propositions of this model:

1. Alcoholism dependence subsumes a variety of syndromes

defined by drinking patterns and the adverse consequences of such drinking.

2. An individual's use of alcohol can be considered as a point on a continuum from non-use, to non-problem drinking, to various degrees of deleterious drinking.
3. The development of alcohol problems follow variable patterns over time.
4. Abstinence bears no necessary relation to rehabilitation.
5. Psychological dependence and physical dependence on alcohol are separate and not necessarily related phenomena.
6. Continued drinking of large doses of alcohol over an extended period of time is likely to initate a process of physical dependence.
7. The population of individuals with alcohol problems is multivariate.
8. Alcohol problems are typically inter related with other life problems, especially when alcohol dependence is long established.
9. Because of the documented strong relationship between drinking behaviour and environmental influences, emphasis should be placed on treatment procedures that relate to the drinking environment of the person.
10. Treatment and rehabilitation services should be designed to provide for continuity of care over an extended period of time. This continuum of services should begin

with effective identification, triage, and referral mechanisms, extended through acute and chronic phases of treatment, and provide follow-up aftercare.

11. Evaluative studies of treatment of alcohol dependence must take into account the initial degree of disability, the potential for change, and an inventory of individual dysfunction in diverse life areas, in addition to drinking behaviour. Assessment of improvement should include both drinking behaviour and behaviours in other life functions, consistent with presenting problems. Degree of improvement must also be recognized. Change in all areas of life function should be assessed on an individual basis. This necessitates using pre-treatment and post-treatment comparison measures of treatment outcome.

This model has been supported by some researchers in the field of alcoholism such as Gottheil, McLellan and Druley (1981). Since it implies that a series of factors are involved in alcoholism treatment, it holds much promise for program evaluation.

C. Epidemiology and Consequences of Alcohol Abuse

The epidemiology of alcoholism is the study of the distribution of this condition in the population. This may be described in terms of 2 factors, incidence or prevalence. Incidence refers to the number of new cases occurring in a specific period. Prevalence refers to the total number of

cases at a specific moment or over a specific period.

Over the past decade there has been a progressive increase in the reported number of alcoholics in Canada (AADAC, 1983). This has been observed even though diagnostic criteria may vary from one setting to another. One estimate (Canada Health Survey, 1981) indicates that over 80% of all Canadians 15 years old and over use alcohol (See Table1). Of these, 10% would eventually develop drinking-related problems.

Table 1

Percentage of Persons (15 years and older) who Drink Alcohol in Canada, 1979.

Type of Drinker	Total %	Males %	Females %
Never Drank	11.5	6.8	16.0
Former Drinker-used to drink but has had no alcoholic drink in last 12 months	3.7	4.4	3.1
Occasional Drinker-drinks alcohol less often than once/month, but has had alcohol beverages within last 12 months	15.1	9.8	20.2
Current Drinker-drinks alcoholic beverages at least once/month	65.3	75.2	55.7
Type of Drinker Unknown	4.4	3.8	5.0
Total	100.0	100.0	100.0

Source: Health of Canadians, 1981, p.23.

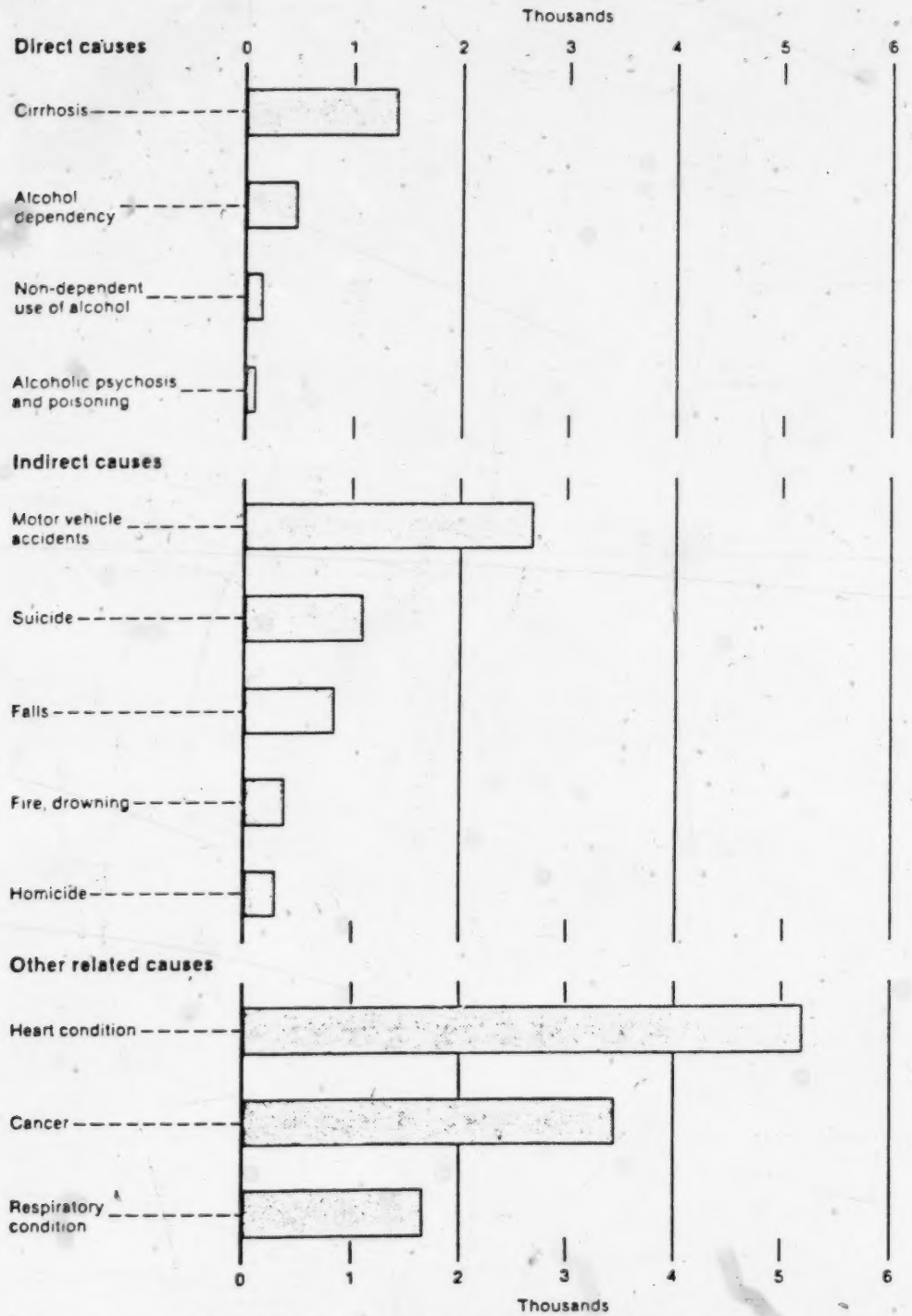

Fig. 1: Estimated alcohol-related deaths, Canada, 1980.

Source: Alcohol in Canada, A National Perspective, 1984, p. 56

The prevalence of alcoholism in Canadian society contributes to widespread social problems. For example, there are numerous conditions which are linked with alcohol consumption and which, directly or indirectly cause death (See Fig. 1). Other conditions linked with alcohol abuse include occupational issues, criminal offences, psychiatric hospital admissions and family issues such as child abuse and divorce. The figures cited in the rest of this section except where indicated, are taken from AADAC (1983) and Health and Welfare Canada (1984).

Direct causes of alcohol-related deaths include cirrhosis of the liver,[1] alcohol dependence, non-dependent use of alcohol and alcoholic psychosis[2] and poisoning. In the case of cirrhosis, it has been estimated that 10 % of long-term heavy drinkers would eventually develop this condition. Further, 60% of all deaths from cirrhosis of the liver can be directly attributed to alcohol abuse. This figure does not include those deaths where alcohol was involved, but not reported. The approximate figure for each of these conditions is given in figure 1.

Alcohol is also implicated as a contributing factor in many other illnesses. Canada wide, alcohol accounts for 22% of deaths from peptic ulcers, 15% of deaths by pneumonia and

---

[1] Cirrhosis is a disease characterized by permanent damage to the liver. Liver cells shrink, die and harden. Scar tissue is formed. Death results if the liver, as a result of this condition, fails to metabolized poisons in the blood.

[2] This is a permanent mental illness characterized by amnesia, disorientation and a general loss of mental faculties.

5.3% of deaths by heart disease (Addiction Research Foundation, 1976).

Deaths indirectly related to alcohol abuse (where drinking was involved) include: motor vehicle accidents, suicides, falls, fires, drownings and homicides. In 1982, 30.4% of all drivers in fatal collisions had consumed alcohol. However, this may be a conservative estimate. Alcohol and other drugs have been implicated as a cause of death in 14% of the total number of suicides in both Canada and Alberta. Approximate figures for other causes of death in 1980 are also given in figure 1.

Alcohol-related problems in the work force result in lower productivity, absenteeism, lower work morale and accidents at work. These problems resulted in an estimated loss of 21 million dollars a day to Canadian industry in 1978.

Although exact figures are not available, alcohol is an implicated factor in many violent crimes. In 1978, it was estimated that between 30 to 51 % of 149,524 reported crimes of violence were alcohol-related. The majority of these offences were physical assault and robbery.

In the field of mental health, the adverse consequences of alcohol abuse are also seen. In 1976, psychiatric units in Canada reported that 13% of male admissions and 3% of female admissions were for alcohol-related disorders.

Finally, in the family, alcohol has been linked with child abuse and divorces among other dysfunctional symptoms.

There is a range of 100-150 incidents of alcohol-related child abuse per 100,000 children per year. In 1978, one-sixth of all divorces in Canada were alcohol-related.

Before concluding this section, it is important to note that alcoholism affects all classes in society. However, there is some evidence that it affects the lower socioeconomic classes more. It has also been shown that alcoholism is more frequent in such ethnic groups as native Canadian Indians, white Protestants and Irish Catholics than among others such as Jews, Moslems or Chinese. Furthermore, it should be emphasized that alcoholics are not a homogeneous population. The effects of alcohol abuse may be different for different sub-population of alcoholics.

D. Definition of Common Terms

1. AADAC: refers to the Alberta Alcoholism and Drug Abuse Commission. AADAC is the Alberta government agency which is responsible for the treatment and rehabilitation of drug and alcohol abusers.
2. West End Centre (WEC): this is an out-patient treatment centre for substance-abusers (alcoholics and drug addicts), located in West Edmomton and operated by AADAC. A description is provided in Chapter III.
3. Day Program: this is the group therapy treatment program of AADAC's WEC. Besides group therapy as the prime treatment modality, it includes a lecture series, relaxation therapy, leisure counselling and recreational

activities. This is described in Chapter III.

4. Alcoholic: for purpose of this study, an alcoholic will be any individual with a drinking problem who was referred to the WEC for treatment. The term is used interchangeably with "client" and "subject".
5. Counsellor: in this study a counsellor will be any individual employed in the WEC who took part in the treatment program. It is used synonymously with therapist.
6. Research Instruments: are the 5 questionnaires used in the study. These are found in Appendices D to H, respectively. The data for this study are taken from Research Instruments #2 (client's self-administered pre-test) and #4 (client's self-administered post-test). See Chapter III, section 3G on instrumentation.
7. Scales: refers to the Drinking-Related Internal-External Scale (DRIE), the Bradburn Affect-Balance Scale (ABS) and the Khavari Alcohol Test (KAT). These are incorporated in client's pre- and post-test and are further discussed in chapter 3, section H.

E. PURPOSE OF STUDY

The main purpose of the present study was to evaluate how alcoholics who participated in AADAC West End Centre's Day Program were coping in different areas of life before and after treatment. Such an empirical investigation has not been previously conducted in Edmonton. As such, there is a

lack of research findings on the impact of the WEC's Treatment Program on the problem of alcohol abuse.

Tasks performed

The following general tasks were performed:

1. Clients were contacted by means of the telephone and were subsequently interviewed using Research Instruments #4 and #5 (See Chapter III, Section G). The former is a structured form while the latter is semi-structured.
2. Any subjective impressions that the clients had regarding the program were recorded. Any other idea(s) from clients which could contribute to the improvement of the quality of services offered by the West End Centre were noted.
3. At the follow-up stage (stages are outlined later) some specific objectives were:
   a. Determining how many subjects were abstinent;
   b. Identifying to what extent clients are happy and contented with their life-style;
   c. Assessing, the extent to which drinking behaviour was modified by the Treatment Program.

Significance of study

The problem of alcoholism is widespread. In Canada, treatment programs such as the Day Program are few and very costly. For this reason, an evaluation is necessary in order determine effectiveness of such programs. The findings will

indicate whether there any changes in specific areas of client lives at follow-up. This information could be useful for personnel and program evaluators.

This study is a pilot project. The Evaluations Branch of AADAC may use the findings to modify existing evaluative instruments, if necessary. It is likely that some of the recommendations made herein may be used in the future to develop and implement more effective follow-up studies .

Therapists at the WEC have expressed an interest in the results of their efforts to help alcoholic subjects live substance-free lifestyles. In the past, feedback was in the form of verbal reports by counsellors and clients. The significance of this study is that it will supplement these reports with empirical findings.

Limitations of Study

This study has the following limitations:

1. Findings are limited to the sample of subjects who completed the Day Treatment Program of AADAC's West End Centre. These subjects were not selected on a random basis from any general population. Hence the findings and conclusions cannot be generalised to any other population of alcoholics.
2. The WEC caters to the treatment of subjects with drug and/or alcohol problems. This study is confined to those subjects with an alcohol problem.
3. The procedure for subject selection, that is, using

volunteer subjects imposes yet another limitation on the extent to which the results can be generalized.

4. The final limitation is related to use of only one group of subjects; the additional use of a control group was not ethically justifiable under the treatment conditions. This made it difficult to attribute findings solely to treatment effects. Rating-interval life events and test-retest were potential sources of internal invalidity in this study.

Chapter II

Review of relevant literature

The view that alcoholism is a disease means that treatment methods must consider its etiological bases. Kissin (1977), based on the work of Seevers (1968) and Jellinek(1960), identified biological, psychological and social causes of alcoholism. This view has been supported by Pattison et al (1977) in their multivariate model of alcoholism outlined in Chapter I.

Thus a variety of treatment methods have been developed in treating alcoholism. These include: psychotherapy (Hill and Blane, 1967; Blum and Blum, 1967; Blume, 1978; Tiebout, 1962); behaviour modification (Bandura, 1969; Ludwig and Wilker, 1974; Miller, 1972; Sobell and Sobell, 1973); and drug therapy (Benor and Ditman, 1967; Ditman, 1966; Kissin, 1977; Viamontes, 1972).

Psychotherapy, a general approach to intrapsychic functioning, while extensively used in practice, has not been clearly defined in the literature. It includes: (a) individual psychotherapy, (b) group psychotherapy, (c) family and couples therapy and (d) Alcoholics Anonymous (A.A.), a self-help group founded in 1935. Some writers regard A.A. as a form of group psychotherapy. Because of the uniqueness of the A.A. approach,[3] it will not be considered

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[3] A.A. is a leaderless but structured group which treats alcoholism using a spiritual approach based on the "12 steps". It holds that alcoholism is a disease which can never be cured. Complete abstinence is the only recovery. In meetings, abstinent speakers relate their experiences. A.A. claims 60% recovery rate, although this is debatable.

as a form of group therapy in this presentation. The common feature of these approaches is that verbal interactions are used to effect emotional or behavioural changes in subjects. Forrest (1978) views group therapy in alcoholism as:

> "An interpersonal transaction involving a group leader, who by virtue of a particular type of educational training and life experience, can potentially help facilitate behavioural growth and change on the part of the other group members, who in this particular group context share the common problem of alcohol addiction" (p. 95)

There are different types of groups. For example, Catanzaro (1968) identifies 4 types: the didactic, interacting, nondirective and analytical groups. He also details special techniques which may be used in group therapy. These include psychodrama, role playing, tape-a-drama, buzz-session and brainstorming.

A group may have several phases. Kanas (1982) outlines 3 different phases of group therapy with alcoholics, with phases 2 and 3 predominating in an outpatient setting. Phase 1 deals with the newly abstinent state and the defence mechanism of denial in the alcoholic. Phase 2 is concerned with important biological, psychological and social sequelae of alcoholic's drinking behaviour. Finally phase 3 deals with the predisposing causes of alcoholism. Examples of these would be genetic predisposition as determined by family history, sociocultural background and neurotic or characterological traits.

---

[3](cont'd) Membership worldwide is around 1 million, in Canada 70,000. See "Alcoholics Anonymous", 1955 for its philosophy.

Within the past two decades, the use of group therapy as a treatment modality for alcoholics has steadily increased along with the claims that this is the most successful form of treatment available for these subjects (Cahn, 1970; Doroff, 1977; Fox 1962, Forrest 1978, Steiner 1971, Stein and Friedman 1971. The view that alcoholics respond best in group therapy has not only been shared by therapists, but by alcoholics as well (Hoffmann, Noem and Petersen, 1975). Doroff (1977), presented a comprehensive overview of the use of group therapy with alcoholics. This chapter will broadly discuss the literature from two perspectives: first, anecdotal reports of group therapy with alcoholics and second, controlled studies.

A. ANECDOTAL REPORTS

Anecdotal reports on the efficacy of group therapy in the treatment of alcoholics is widespread. This mode of treatment has been used in a variety of contexts operating on different theoretical bases.

Feibel (1960), Greenbaum (1954) and Martensen-Larsen (1956) used psycho-analytical principles in group therapy with alcoholics. Feibel (1960) saw the task of the therapist and group as that of strengthening the ego of the alcoholic client. In the beginning, according to him, the client cannot accept himself as an alcoholic. As treatment proceeds, his defence mechanism of denial and fear of verbally expressing aggressive and sexual impulses diminish.

This results in increased ego strength and a greater ability to abstain from alcohol.

Greenbaum advocated the use of disulfiram (Antabuse)[4] as an adjunct treatment to group psycotherapy. A frequency of 3 one-hour sessions per week was seen as optimal. He found that most patients responded positively to group therapy in terms of increased self-esteem, improved interpersonal relations, higher tolerance to frustration and more adequate handling of hostility.

Martensen-Learsen argued that group therapy is also applicable to relatives of alcoholics and can be used in mixed groups consisting of alcoholics and relatives of alcoholics.

Other therapists such as Fox (1962) advocated group therapy as part of a total treatment program which can include such factors as hospitalization, medication, antabuse, and A.A. She argued that for group therapy to be effective it is first necessary for the alcoholic to be sober. She further pointed out that the resistance of the alcoholic is the resistance to sobriety and the advantages of being an alcoholic. Fox said that all therapists should identify and articulate this issue in group treatment with alcoholics.

Psychodrama is a method of group psychotherapy originated by Moreno (Moreno, 1946). In an early paper

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[4] Antabuse taken in combination with alcohol results in discomforting physical symptoms such as flushing of the skin, dizziness, pounding of the heart, throbbing of the head and nausea. This usually last for 2-3 hours.

Evseeff (1948) described the use of this technique with alcoholics at the Traverse City State Hospital in Colorado, U.S. Blume (1974) outlines the 3 following stages of psychodrama. (a) Warm up: in which the director and group prepare for therapeutic work; (b) Psychodrama proper: a "protagonist" (central figure in the psychodrama) emerges from the group, and with the help of the director, sets up and re- or pre- lives from his past, present, future, or fantasy life. Other group members serve as "auxilliary egos", playing roles in the scenes as needed; (c) Sharing: in which techniques are used to deepen the protagonist's insight into his feelings and behaviour. The session ends with a sharing of feelings by all involved.

The aim in psychodrama, according to Blume (1974) is to "deepen the insight of the group members into the psychodynamics of their drinking and their sobriety" (p. 125).

Brunner-Orne and Orne (1954) used "directive group therapy" in a permissive, yet supportive setting. These researchers distinguished their work from Rogerian non-directive therapy. For these clinicians, the immediate therapeutic goal in group work with alcoholics was the achievement of sobriety. They saw this as a prerequisite for personality growth in the alcoholic. They also saw directive group therapy as providing relief of unpleasant feelings such as anxiety and guilt in the alcoholic.

Miller, Dvorak and Turner (1960) applied aversion therapy (drugs) in group therapy with alcoholics. Twenty white males served as subjects. He was able to show that Pavlovian conditioning or associative learning can be established in a group setting. However, he was unable to draw any conclusions about the effectiveness of conditioned treatment in a group setting as a treatment modality in alcoholism.

Steiner (1971) used the principles of transactional analysis (T.A.)[5] in group therapy with alcoholics. He identified 4 principles of group work:

(a) leader who, in a contractual form of treatment, is the therapist.

(b) the group should consist of 6 to 12 patients, ideally 8.

(c) drinking behaviour can be modified by verbal therapy (T.A.) and

(d) the ideal group is one which consists of individuals who are different in as many dimensions as possible.

The basic goal in transaction analysis is to assist the alcoholic to make new decisions regarding his drinking behaviour and the direction of his life.

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[5] Transactional Analysis is an interactional psychotherapy particularly appropriate for groups. It was developed by Eric Berne (See Berne, 1961, 1964, 1966) and emphasizes the client developing a contract and making decisions for himself.

Mullan and Sanguiliano (1966) identified an alcoholic population within whom group psychotherapy would be most effective. These would have to meet the following criteria:

(1) willing to admit they are alcoholic;

(2) interested in psychotherapy;

(3) can involve themselves in other treatment such as disulfuram and/or AA membership;

(4) show some degree of insight and psychological ability and a committment to keeping appointments; and

(5) have evidence of anxiety along with efforts at achieving sobriety.

On the other hand, alcoholics who showed evidence of psychotic behaviour, inability to establish a relationship with the therapist or severe physical impairment were deemed unsuitable for group therapy.

Furthermore, these authors recommended several hours of psychotherapy with the group therapist prior to the group meeting. They also stressed the use of group therapy with vocational counselling, social casework, and community resources such as Alcoholics Anonymous or a Half-way House‘

Finally, Zimberg (1978) proposed nine basic principles that are crucial to the treatment of alcoholics by group

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‘ Half-way House refers to a relatively small residential unit where alcoholics can stay for a limited period of time. It represents any half-way place in a progress, in this case, recovery from alcoholism.

therapy:

(1) use of a homogenous group consisting of alcoholics exclusively;

(2) structured rather than free-floating group process;

(3) group therapy as a part of multimodality approaches to the treatment of alcoholism;

(4) group leader should direct and yet be permissive and supporting;

(5) efforts should be directed to the drinking behaviour as the first step in group therapy;

(6) intense transference of the alcoholic should be understood by group therapist and group members should be used to diffuse this intense transference;

(7) there should be specific criteria for inclusion and exclusion of alcoholics in group therapy since not all may be suitable for group work;

(8) there should be scope for role modelling by therapist; and

(9) therapist in the early sessions should ally himself with the alcoholics psychological needs rather than attacking the client's defences except in the case of denial of alcoholism by the client.

As the above studies show, group therapy, based on various theoretical approaches, has been widely used as a treatment modality for alcoholics. These studies further suggests that the characteristics of the client, the group and the therapist, as well as the structure of the group process influence the outcome of therapy.

B. EMPIRICAL STUDIES

A survey of the literature reveals that few empirical studies have been conducted to investigate the utility of group therapy in the treatment of alcoholism. Nevertheless, these may basically be classified into 2 categories: (i) those that found no evidence for the efficacy of group therapy as a treatment modality and (ii) those that found evidence in favour of group therapy in the treatment of alcoholism. These categories are further explored in the following section.

The non-effectiveness of group therapy has been demonstrated by many investigators. Kissin, Rosenblatt and Machover (1968) randomly assigned subjects to one of four conditions: no treatment, outpatient drug therapy, outpatient group therapy plus drug therapy, or inpatient treatment. These reseachers found that the subjects who received both drug and group therapy showed no more improvement than those receiving drugs alone, although all three treatment groups did better than an untreated sample.

Similarly, Wolff (1968) found no significant differences in abstinence rates between his group therapy subjects and an untreated control group at a six-month follow-up. Nevertheless, he concluded that "group psychotherapy can be moderately successful in improving alcoholic patients if it focuses on motivation for change" (p.209). According to Wolff, for the alcoholic to control his drinking, he has to develop a goal and purpose in life.

Miller, Hersen, Eisler and Hemphill (1973) used 3 groups of 10 subjects to compare the effects of group therapy (confrontation psychotherapy) with electrical aversion conditioning (high shock paired with alcohol sips) and control conditioning (very low shock paired with alcohol sips). After 10 days, they found no significant differences between these 3 conditions regarding reduced alcohol consumption or improved attitude towards drinking. However, because of the small sample size used in this study (N=30), the findings should be treated with some degree of caution.

A few evaluation studies such as Ends and Page (1957, 1959) have shown positive short-term gain in psychological test measures as a result of group therapy in inpatient settings. For instance, Ends and Page (1957) compared the effects of three types of group psychotherapy, based on learning theory, client-centred therapy, and psychoanalysis, with the effects of a discussion group which served as a control, on a sample of 63 alcoholics in an inpatient setting. After 15 sessions, they found that significantly

more client-centred and psychoanalytic patients showed improved self-concept than control patients, as measured by Q-sort ratings and 18 months follow-up. Furthermore, significantly fewer client-centred patients required re-admission than controls.

In a second study of client-centred group psychotherapy, Ends and Page (1959) found this type of treatment to be superior to a control condition on the basis of Q-sort ratings and scores on the Minnesota Multiphasic Personality Inventory (MMPI). They also found that doubling the number of sessions from 15 to 30 in a six-week period of time resulted in both quantitative and qualitative improvement, particularly in the area of self-acceptance, self-ideal and in general, psychological growth.

McGinnis (1963) investigated the effects of group therapy on the Barron Ego-Strength Scale scores of the alcoholic patient. Subjects were divided into two groups, one receiving AA and group therapy and the other AA alone (control). After 7 sessions lasting 1.5 hours each, he found that group psychotherapy patients displayed significant improvement in the Scale scores.

Yalom (1974, 1975) applied insight-oriented interactional group therapy[7] in conducting group work with alcoholics. In a 1978 study, Yalom, Bloch, Bond, Zimmerman and Qualls studied the effect of this method on a sample of

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[7] Interactional Group Therapy focuses on maladaptive behaviour patterns that the client uses to structure his or her relationships. It depends almost exclusively on therapist-client interaction for enacting change.

20 alcoholics and 14 neurotic patients. Subjects met weekly in a outpatient clinic. Outcome assessment was obtained from 3 sources: patients, therapists and independent judges using both nomothetic and ideographic measures. The former was the attainment of specified therapeutic goals while the latter was a 9-point rating scale evaluating improvement in symptoms. They found (a) significant improvement in both samples after 8 and 12 months of therapy; (b) no significant differences in improvement between the alcoholic and the neurotic groups.

Finally, in a recent outcome study, Cronkite and Moos (1984) used group therapy with a sample of 332 subject (males and females). They compared drinking behaviour of 4 sub-groups on several distinct intake and outcome criteria. Subjects in the sub-groups were classified according to gender and marital status. These researchers found that: (a) participation in group therapy is related to better outcome for men relative to women and (b) exposure to educational materials on alcoholism is associated with better outcome of women relative to men. Men and women also differed in their perceptions of the treatment environment in relation to outcome.

To conclude, even though group therapy is widely believed to be an effective method of treating alcoholics, there has been comparatively small amount of empirical research to validate this belief.

This study investigates the efficacy of AADAC's WEC Treatment Program which employs group therapy as the prime treatment modality. The sample size is 34 subjects. A pre-post test design is employed to determine if changes will occur in certain areas of subjects' lives after treatment. These areas are: (a) drinking-related locus of control, (b) overall happiness and (c) drinking behaviour.

In order to do so, the following null hypotheses (H_o) are examined:

(1) there will be no differences in means for DRIE at the pre- and post-stages;

(2) pre- and post-test scores for the Bradburn scale will not be significantly different after treatment; and

(3) for the subjects, there will be no significant differences in the Khavari Alcohol Test Scores from pre- to post-test.

Chapter III

Methodology

A. SETTING

The study was conducted at AADAC's West End Centre (WEC), founded in May 1975 and located in west Edmonton.

There are two major objectives of this centre. These are:

1. To provide counselling, information, education and selected prevention programs to clients and members of the community who seek assistance with chemical dependency problems.
2. To provide specialized treatment services to opiate dependent persons in the Edmonton area and the Province of Alberta at large.

Subjects were referred to the WEC from various sources, listed in Table 2. The largest number were from AADAC's Detox Centre while self-referrals comprised the second largest group. Other sources included Alberta's out-patient clinics and the judicial-correctional system.

There is a total of 17 staff at the WEC. Of these, 9 were actively involved in the educational part of the treatment program and 2 were primarily responsible for group therapy, the second component. These 2 counsellors, one male and one female had received college-training and had 7 and 10 years of counselling experience repectively.

Table 2

Referral Sources of Subjects: frequency distribution

REFERRAL SOURCES	FREQUENCY	PERCENT
DETOX CENTRE	12	35.3
SELF	8	23.5
OUTPATIENT CLINIC	3	8.8
JUDICIAL-CORRECTIONS	2	5.9
PROBATION	1	2.9
POLICE	1	2.9
HOSPITAL	1	2.9
EMPLOYER	1	2.9
GOVERNMENT AGENCY	1	2.9
RELATIVE-FRIEND	1	2.9
OTHER	1	2.9
MISSING CASES	2	5.9
TOTAL	34	100.00

B. TREATMENT

The treatment in this study was the 2-week out-patient Day Program of AADAC's West End Centre. Its main objectives were to give substance abusers (alcoholics and drug addicts) knowledge of chemical addiction and an opportunity to examine addictions-related problems in a group context.

The major components of this Program were a lecture series and group therapy. Before these are examined in detail, the admission criteria and intake procedure are outlined.

Admission Criteria

Clients were expected to:

1. attend a one-day orientation on the Friday just prior to commencing the Day Program;
2. attend consistently on a daily basis for a full 2 weeks including a preliminary day of orientation;
3. admit and discuss any drug and alcohol use that occurred during their two weeks in the group;
4. be in the program because they want to change;
5. participate and share thoughts and feelings that are appropiate and relevant;
6. respect and strictly adhere to group confidentiality;
7. be drug/alocohol free (except for medications prescribed by a doctor) while in treatment.

Subjects who were psychotic, severly depressed or extremely manic were excluded from the group. Those who missed more than one half-day of the program were required

to terminate attendance and, if they desired, to commence again on a future orientation day.

Intake Procedure

Orientation of subjects took place every second Friday (10 am - 4 pm) during the months of March - May, 1984. An outline of the Orientation Day format is given in Appendix "A". Subjects who attended the orientation comprised one group; no new members were added during the 2 weeks of treatment. Members began the program the Monday following the completion of the Friday orientation.

On Orientation Day or while actually attending the program, each subject was interviewed by a counsellor. During this interview, the subject completed Res. Inst. #2 while the counsellor completed Inst. #1 and #3. (See Appendices, E, D, and F.)

Lecture Series

The information component of the Day Program consisted of a series of lectures and films with related discussions on different aspects of chemical dependency (alcohol and drug abuse). Lectures were presented for 2 hours (10:00 am - 12:00 noon) with a mid-morning break included. The series was repeated every 2 weeks. It was also progressively informative on the nature of substance abuse. For example, lecture 2 built upon concepts that were introduced in lecture 1.

The objectives of the lecture series were:

1. to provide basic and specific information about chemical

dependency;

2. to increase clients' knowledge and awareness about the problems associated with drug and alcohol abuse;
3. to provide clients with alternative ways to deal with these problems; and
4. to help clients understand the effects of chemical dependency on personal relationships.

To achieve these objectives, the following topics were discussed:

WEEK 1	Corresponding Days of Week
(i). A new look at chemical dependency	Monday
(ii). What is addiction?	Tuesday
(iii). Discussion regarding above lectures	Wednesday
(iv). Effects on relationships	Thursday
(v). Alcoholics Anonymous	Friday AM
(vi). Recreational outing	Friday PM

WEEK 2	
(vii). Drugs and dependency	Monday
(viii). Effects of alcohol on the body	Tuesday
(ix). Self-esteem	Wednesday
(x). Relapse prevention	Thursday
(xi). Goals and life style	Friday AM
(xii). Alcoholics Anonymous	Friday PM

Appendix B is a synopsis of the key ideas of and teaching strategies used in each of the above lectures, except in the case of Alcoholics Anonymous which has already been discussed.

Group Therapy

In this study group therapy also included several sessions of relaxation therapy, one session of recreational outing and one session of leisure counselling. Group therapy proper was held from 1:00 pm to 3:15 pm, with a mid-session break for 15 minutes. Relaxation therapy, later described, was held for half an hour after group therapy concluded.

Each group was led by a staff member. There were a maximum of 10-12 clients per group. The task of the staff was basically to promote discussions and facilitate interactions among group members. Discussion often involved issues from the morning lectures in so far as these related to the subjects' lives and other alcohol or drug-related problems. Subjects interacted with each other as they shared experiences, explored feelings and in general increased their awareness of addiction-related problems. They were encouraged to be open in the sense of appropiately self-disclosing.

The group therapy model used was mainly an interactional, client-centred approach based on the work of Carl Rogers (1951, 1961). Other techniques applied, based on the individual needs of the client and the collective needs of the group, were from Reality Therapy (Glasser, 1965) and

Gestalt Therapy (Perls, 1973; Perls, Hefferline and Goodman, 1951).

Relaxation Therapy

At the conclusion of group therapy, a recreation therapist* led the group in relaxation training for a 1/2 hour.

The goals of relaxation therapy were: (a) to help the clients relax after dealing with the issues that were covered during the day's lecture and/or group therapy; (b) to provide an alternative means of relaxation for persons who depend on alcohol and/or drugs to relax; (c) to make clients more aware of potential stress buildup in the body and ways to relieve this stress. Clients were taught many techniques of relaxation therapy in the group and encouraged to practise these on their own. Some relaxation techniques are described in Appendix C.

Recreational Outing

On a Friday afternoon during the program, accompanied by a staff, the clients went on a recreational outing. The aims of the recreation outing were:

1. to allow the clients as a group to enjoy a leisure activity which promoted group trust and cohensiveness;
2. to introduce them to a community recreation facility (eg Kinsmen Aquatic Centre, Laurier Park, Provincial Museum etc) and the leisure potential of that facility; and

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* The recreation therapist is a staff at the WEC. He is not one of the 2 staff directly responsible for group therapy.

3. to get the clients involved as a group in a leisure activity that they may not have participated in for some time and one they could easily take up if they found it enjoyable.

Leisure Counselling

Finally, during the duration of the program, each subject had one session of leisure counselling with the recreation therapist. In this session, the counsellor assessed: (a) the client's leisure interests and skills and (b) the extent to which the client's addiction adversely affected his involvement in leisure activities. Furthermore, the counsellor determined individual client's needs in terms of variety of interests, skills, finances and motivation, and discussed these with the client. The client was encouraged to set up leisure goals. If there was a need, follow-up leisure counselling was arranged for ongoing support and assistance in achieving these goals.

C. SAMPLE

Alcoholics who were referred to the WEC served as subjects for this study. Subjects eligible for inclusion were defined as those who had completed all 3 phases of the study as outlined in the following section 3(D) (See Table 4).

The sample consisted of a total of 34 subjects, of which 20 were males and 14 females (See Fig. 2). Selected demographic characteristics are presented in Table 3. The

age-distribution of subjects is shown in Fig. 3 (there were 2 missing cases).

Table 3

Selected Pretreatment Demographic Characteristics of Subjects

Demographic Variables:		
Age :	Mean	= 40.19 years
	Standard Deviation	= 12.82 years
	Range	= 17-63 years
	2 missing cases	
Sex:	20 males	= 58.8%
	14 females	= 41.2%
Marital Status :	16 married	= 47.1%
	7 single	= 20.6%
	5 divorced	= 14.7%
	3 separated	= 8.8%
	1 widowed	= 2.9%
	2 missing cases	= 5.9%
Previous Occupation:	8 Manufac-Construction	= 23.5%
	5 Service-Sales	= 14.7%
	4 Transport Equip Oper	= 11.8%
	2 Houseworker	= 5.9%
	2 Student	= 5.9%
	2 Farming	= 5.9%
	1 Natural Sciences	= 2.9%
	1 Teaching	= 2.9%
	1 Medicine Health	= 2.9%
	1 Clerical Library	= 2.9%
	1 Retired	= 2.9%
	1 Other	= 2.9%
	1 None	= 2.9%
	4 Missing Cases	= 11.8%

Current Employment Status :	23	Unemployed	= 67.6%
	6	Full-time	= 17.6%
	1	Retired	= 2.9%
	1	Houseworker	= 2.9%
	1	Student	= 2.9%
	2	Missing Cases	= 5.9%
Type of Previous Treatment at AADAC :	12	Not Applicable	= 35.3%
	10	Outpatient	= 29.4%
	8	Detox	= 23.5%
	2	Inpatient	= 5.9%
	2	Missing Cases	= 5.9%
Highest Post-Secondary Education	18	none	= 52.9%
	3	Vocational Training	= 8.8%
	3	Some Technical School	= 8.8%
	3	Technical School Diploma	= 8.8%
	2	University-College Degree	= 5.9%
	1	Some University - College	= 2.9%
	4	Missing	= 11.8%

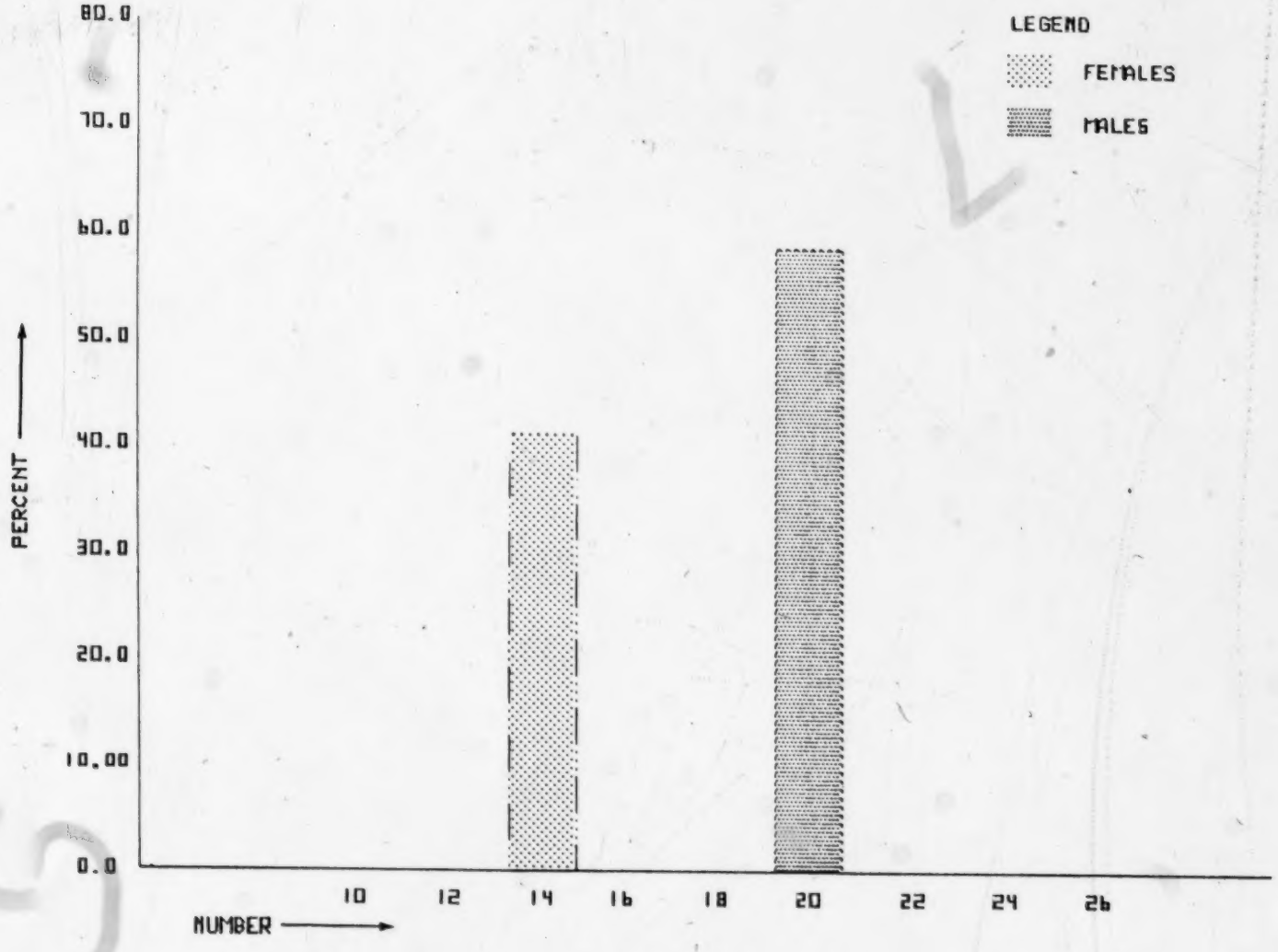

FIG. 2: PERCENTAGE OF MALES AND FEMALES IN SAMPLE (N=34)

FIG. 3: AGE DISTRIBUTION OF SUBJECTS (N=34)

D. DATA COLLECTION AND ATTRITION

The procedure used in data collection in this study may be described in terms of the 3 stages of the study. In the first stage, subjects admitted to the Day Program were requested to complete Research Instrument (Res. Inst) #2, the *client pre-test*. The intake counsellor at WEC completed Res. Inst. #1 and #3 as described in Section 3G.

The total number of subjects who completed Res. Inst. #2 on the Orientation days was 83 (100%). There were 6 cases (7.2%) of missing data as a result of intake counsellor(s) failing to complete Res. Inst. #1 and #3. These cases were later excluded from this study (See Tables 4, 5).

Treatment in the form of the Day Program was then implemented. This constitutes Stage 2. However, not all subjects completed the entire program. There were 6 (7.2%) subjects who withdrew from treatment or attended only part of it.

After a 3-month intervening period following completion of the Day Program, 50 (60.2%) of subjects were contacted by telephone and/or letter to complete Stage 3 of the study. This stage involved face-to-face interview with clients who had participated in the program in March, April and May'84. They were interviewed in June, July and August of the same year respectively. During this interview, subjects completed Res. Inst. #4, the *client post-test*. They also provided

information for Res. Inst. #5 which was recorded by the writer.

From the 50 contacted subjects, 34 (40.9%) completed all 3 stages of the study. A breakdown of the number of subjects involved at different stages of the study, accompanying attrition figures and reasons are given in Tables 4 and 5.

Table 4

Number of Subjects involved at different stages of the study

No. of subjects	Attrition number	Descriptor
Stage 1: Pre-treatment		
83		
Stage 2: Treatment (Day Program)		
83		Started Day Program
	6	Did not complete Day Program
77		Completed Day Program
Interstage2-stage3: 3-month period		
	17	Not contactable
	6	Incomplete data (RI #1, RI #3)
	3	Left province
	1	Death
	27	
Stage3: Post-treatment		
50		Contacted at start of stage 3
	14	Failed to appear for interview
	1	Failed to return RI #4
	1	Refused to return RI #4
	16	
34		Completed all stages of study

Table 5

Data Attrition Figures for Study

Reason	Number of Subjects	Percent of Total (N=83)
Stage 1		
(a) Counsellors did not complete Research Instruments #1, #3	6	7.2
Stage 2		
(b) Withdrew from treatment or attended only part of it	6	7.2
Stage 3		
(c) Contacted but failed to appear for interview	14	16.9
(d) Contacted but refused to complete Research Inst. #4	1	1.2
(e) Contacted but failed to return Research Inst. #4	1	1.2
(f) Not contactable	17	20.5
(g) Left province (Alberta)	3	3.6
(f) Death	1	1.2
Total	49	59.0

E. RESEARCH DESIGN

To evaluate the impact of the treatment program, the pre-experimental research design was used (Campbell and Stanley, 1966). As these authors point out, this type of quasi-experimental design approximates but does not meet the requirements of a true experimental design. It may be represented as

R_1 ----------> T ----------> R_2

pre-treatment rating — treatment — post-treatment rating

Each subject serves as his or her own control. There is no control group, a condition which precludes making group comparisons or contrasts.

At admission (N=34) subjects were tested (R_1) on the following 3 scales: DRIE, Bradburn and Khavari Alcohol Test. These scales were incorporated in the pre-test, Res. Inst. #2. At follow-up 3 months later, clients were rated (R_2) on the same measures on the post-test, Res. Inst. #4 (See Chapter 3). Significant differences between pre- and post-tests were taken to indicate the effectiveness of the treatment program.

F. RATIONALE FOR RESEARCH DESIGN

The design used in this study is one of convenience. It is used to evaluate an existing service. One pertinent point in this study is that it was not possible for counsellors at the WEC to exercise the degree of control necessary in a

true experimental sense .

There are basically two reasons for this : (a) the independent variable, in this case the treatment program at the WEC, could not be manipulated by the researcher; (b) bearing in mind that referred subjects suffer from a variety of alcohol-related problems, a random assignment of subjects into control and treatment groups would have been highly unethical and out of the jurisdiction of the WEC.

The methodological strength of this design is that the same clients are measured before and after treatment, that is, at follow-up. This yields cleaner data than does a cohort sample, since between-subject error is eliminated.

The methodological weakness of this design is that although it permits the researcher to measure changes objectively, such changes cannot necessarily be attributed to the treatment program. Possible sources of error in this study are described in the discussion on findings, chapter 5.

G. INSTRUMENTATION

The research instruments used for data collection in this study were five (5) questionnaires. These are described in the following section.

RESEARCH INSTRUMENT (#)	DESCRIPTOR
# 1	AADAC ADMISSION/DISCHARGE FORM
# 2	CLIENT'S SELF-ADMINISTERED PRE-TEST
# 3	COUNSELLOR'S PRE-TEST ASSESSMENT FORM
# 4	CLIENT'S SELF-ADMINISTERED POST-TEST
# 5	COUNSELLOR'S POST-TEST ASSESSMENT FORM

All the above instruments were devised by AADAC's Evaluation Branch, Edmonton. The writer provided identification names for instruments (2)-(5).

Research Instrument #1 was a structured questionnaire dealing with demographic data of subjects. It was divided into 3 sections - identification, admission and discharge data of subjects (See Appendix D).

Instruments #2, #3, and #4 focussed on various aspects of clients' lives. From face validity, the information collected in these instruments, and to a lesser degree, Res. Inst. #5, were in the areas of :

(a) emotional functioning,
(b) physical health,
(c) leisure time satisfaction,
(d) work satisfaction,
(e) professional resources,
(f) self-help resources,
(g) drinking behaviour, and

(h) drug use frequency.

Like res. inst. #1, these were all structured questionnaires (See Appendices E, F, and G).

Res. Inst. #5 was a semi-structured questionnaire. It covered different aspects of the treatment Program as well as other features of the West End Centre. It included several open-ended questions and was perhaps the most comprehensive of the research instruments (See Appendix H).

Res. Inst. #2 and #4, the Client's Pre- and Post Self-Administered Tests, incorporates together with other questions, the following 3 scales :

(i) Drinking-related Internal External Scale (DRIE),

(ii)Bradburn's Happiness Scale, and

(iii)Khavari Alcohol Test.

Outcome variables associated with (i), (ii) and (iii) above are given in Table 6.

Table 6

Outcome Variable, Descriptors and Sources.(DRIE, ABS, KAT)

	Outcome Variable	Descriptor	Item Source: Res. Inst.	Question
	DRiE Scale			
Pre-test	item 1	Helplessness	#2	14A
Post-test			#4	16A
Pre-test	item 2	Breaks needed	#2	14B
post-test			#4	16B
pre-test	item 3	Arguments cause drinking	#2	14C
post-test			#4	16C
pre-test	item 4	Sobriety requires breaks	#2	14D
post-test			#4	16D
pre-test	item 5	See bottle need drink	#2	14E
post-test			#4	16E
pre-test	item 6	Others drive to drink	#2	14F
post-test			#4	16F
pre-test	item 7	Parties cause drinking	#2	14G
post-test			#4	16G
pre-test	item 8	Cannot resist a drink	#2	14H
post-test			#4	16H
pre-test	item 9	Can't understand others' control	#2	14I
post-test			#4	16I

Table 6 (continued)

Outcome Variable	Descriptor	Item Source Res. Inst.	Question
ABS(Bradburn)			
pre-test item 1	Top of world	#2	2A
post-test		#4	1A
pre-test item 2	Lonely	#2	2B
post-test		#4	1B
pre-test item 3	Excited	#2	2C
post-test		#4	1C
pre-test item 4	Depressed	#2	2D
post-test		#4	1D
pre-test item 5	Pleased Accomplished	#2	2E
post-test		#4	1E
pre-test item 6	Bored	#2	2F
post-test		#4	1F
pre-test item 7	Proud	#2	2G
post-test		#4	1G
pre-test item 8	Restless	#2	2H
post-test		#4	1H
pre-test item 9	Things going way	#2	2I
post-test		#4	1I

Outcome Variable	Descriptor	Item Source Res. Inst.	Question
ABS(Bradburn)			
pre-test item 10	Upset	#2	2J
post-test		#4	1J
pre-test item 11	Overall	#2	2
post-test		#4	1
KAT(Khavari)			
pre-test	Average Frequency	#2	11
post-test		#4	13
pre-test	High Frequency	#2	13B
post-test		#4	15B
pre-test	Average Volume	#2	12
post-test		#4	14
pre-test	High Volume	#2	13A
post-test		#4	15A

H. Rationale for Scales

In the following section, the rationale for the scales used in this study (DRIE, ABS, and KAT) will be discussed. The discussion in each case will focus on the development of each scale, empirical applications and relevance to this study.

(1) Drinking-related Internal External Scale (DRIE)

The concept of locus of control was developed within Social Learning Theory to refer to the degree to which a person perceives events as contingent on his or her own behaviour

or characteristics (Rotter 1966, 1975). Rotter's Internal-External (I-E) scale is a broad based measure of an individual's general expectancies of reinforcement.

An individual with an internal locus of control generally believes that his behaviour influences events, so he is more likely to make an effort to effect changes in himself or in the world around him. A person with an external locus of control tends to believe that events are as a result of fate, chance or powerful others. He is not likely, therefore, to perceive his own influence on events or to attempt to change them.

The DRIE scale represents the translation of generalized expectancies for locus of control into a measure of specific expectancies dealing with a variety of drinking behaviours. (Oziel, Obitz and Keyson, 1972; Donovan and O'Leary, 1978; Walker, Nast, Chaney and O'Leary, 1979). It was developed after Rotter (1975) pointed out that the generality of his Internal-External Scale led to a low level of prediction across a variety of situations. Other researchers (Nerviano and Gross, 1976; Rohsenow and O'Leary, 1978 a,b) saw the need for a more specific measure of control orientation for the prediction of alcohol related behaviour.

Oziel, Obitz and Keyson (1972) found scores on the DRIE scale correlated significantly with Rotter's general Locus of Control Scale (1966). Furthermore, Donovan and O'Leary (1978), using the DRIE scale were able to identify

significant differences between alcoholics and non-alcoholics in a sample of 120 males. They wrote:

> "the DRIE scale is a reliable, multidimensional measure of alcoholics' specific expectations concerning drinking behaviour. The scale has demonstrated both convergent and discriminant concurrent validity as well as construct validity". (p.778-779)

They also theorized that this more narrowly defined, topic-specific, measure of locus of control may increase predictive power and thus help to clarify equivocal results.

The DRIE scale was also used as a predictor of relapse (Kivlahan, Donovan, and Walker, 1983). In a nine-month follow-up study of a sample of 232 male alcoholics, these authors found that those who either relapsed after treatment or were lost to followup had significantly more external DRIE scores.

Finally, the Scale effectively predicted therapy involvement during, and treatment outcome following an abstinence-oriented inpatient program for alcoholics which was based upon a philosophy of alcoholics anonymous (AA) (Abbott, 1984). According to Abbott, the DRIE scale in combination with a neuropsychological battery would increase the power of predicting alcohol treatment outcome.

Thus, in the writer's opinion, the DRIE scale was a sound psychometric instrument for this study.

2. BRADBURN Affect-Balance Scale (ABS)

Bradburn and Caplovitz (1965), in a pilot study conducted by the National Opinion Research Centre (US), attempted to develop operational measures for problems in living. They used 5 different samples, a total of 2,787 subjects drawn from different areas of the US.

For their independent variable, these researchers used avowed happiness or the feeling of psychological well-being. The Bradburn Affect-Balance Scale was used to measure psychological well-being. Bradburn (1969) cited evidence to show that changes in affect measures on the scale varied with appropriate changes in avowed happiness.

The Bradburn Scale was also used in the Canada Health Survey (1981)' as a measure of the degree of happiness of Canadians in their day-to-day living.

According to the authors of that survey, the scale "provides an acceptably valid and reliable measure of psychological well-being. It is particularly useful for measuring positive mental affect." (p. 129). In this study, the calculated Cronbach alpha reliability coefficient is 0.80.

In a recent study conducted by the National Opinion Research Centre (US), Macdonald (1983) used it to explore the extent to which personal networks, such as family and friendship ties play a role in the recovery from alcoholism

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' The Canada Health Survey obtained its information through a self-administered questionnaire completed by persons 15 years and older during 1978-1979.

in women.

As Bradburn (1969) points out, the item questions of the scale may not necessarily sample the whole range of emotions people experience at different times. Furthermore, to measure happiness in terms of 2 types of feelings which are taken to be independent is rather simplistic. Nevertheless, the scale has shown to be empirically valid and was considered appropiate for this study.

H. 3 Khavari Alcohol Test (KAT)

The Khavari Alcohol Test is a quantitative indexing of the various dimensions and levels of alcohol consumption. It was developed by Khavari and Farber (1978) at the University of Wisconsin from a sample of 2303 subjects (men and women). According to these authors:

> "several features ... make the test attractive for research and clinical objectives, including the ease of data collection and precise qualification, appropriateness of the data for powerful statistical analyses, construction of a graphic yet quantitative, profile of drinking patterns of individuals or groups and ready comparison of an individual's or group's pattern against the population norms"(p. 1527)

While a survey of the literature reveals that the KAT has not been extensively used in alcoholic research, recent studies indicate that it is becoming increasingly popular. For example, Ansel (1984) applied the KAT in a study to examine the interpersonal dynamics of the interaction between treatment personnel and alcoholic abusers in an alcohol treatment outcome study. Extent of clients' alcohol

consumption rate was reliably measured by the Khavari Alcohol Test. Furthermore, Burkhart and Ratliff (1984) used it in a study of 140 college students (70 males and 70 females) in order to determine sex differences in motivations for, and effects of drinking.

As these studies assert, the KAT is a reliable quantitative measure of subjects' alcohol utilization. For example, in the 1978 study, the reliability coefficient (Cronbach alpha) was 0.77. Thus KAT was judged an appropiate measure for this study.

I. Scoring Procedures:

(1)Drinking-Related Internal External Scale.

The original DRIE Scale consisted of 25 items in a forced-choice format. An example of an item would be, "I feel so helpless in some situations that I need a drink". Subjects were asked to choose their most appropiate response from a 5-point Likert Scale.

In this study, the complete documentation for this Scale was not available. Instead 3 of the highest loading items for each of the 3 main factors as reported by Donovan and O'Leary (1978), later discussed in Chapter IV, were used. Since these authors reported only external items, subjects were asked to agree or disagree with statements on a 5-point Likert Scale with 1 equalling agree and 5 equalling strongly disagree.

(2) Bradburn Affect - Balance Scale

The Bradburn Affect-Balance Scale is a general measure of psychological well-being (Bradburn, 1969). The original version consisted of 10 questions about various aspects of the respondent's emotional state. Subjects were asked to indicate the frequency they experienced different affective states. Scores were independently analyzed.

In this study, the Bradburn Scale (items 1-10) was used in its entirety. Item 11 was an additional summary question on the scale. Original scale measurements were changed from a yes-no format to a 4-point reverse Likert reverse scale ranging from "never", "scarcely", "sometimes" and "often". The central score was 2; a lower score indicated the predominance of negative feelings whereas a higher score indicated the predominance of positive feelings.

(3) Khavari Alcohol Test

The original Khavari Alcohol Test asked for volumes of each of beer, wine, spirits and liquors. Due to time limitations, subjects were asked to estimate total consumption over all liquor types.

Since the time scale for the study was three-months rather than one year, relevant retrospective time measures were related to the three month period preceeding the subject's last drink. In addition, the length of time

between the subject's last drink and the respective interview date was determined. Finally, the number of drinks reponse categories were: 1 drink per occasion; 2-5 drinks per occasion; 6-11 drinks per occasion; 12-17 drinks per occasion and 18 or more drinks per occasion.

These categories correspond to minimum of one bottle of beer, two bottles of beer, six bottles of beers, a dozen bottles of beer and one-and-a-half dozen bottles of beer per drinking occasion. For liquor, the minimums correspond to one drink, two drinks, 6 drinks (one-third of a bottle), 12 drinks (two-thirds of a bottle) and 18 drinks (a bottle). For wine, the minimums correspond to one glass, two glasses, 6 glasses (about one bottle), 12 glasses (a little over 2 bottles) and 18 glasses (about three-and-a-half bottles).

The drinks per occasion were standardized by taking category midpoints, multiplying them by 1.5 ounces and multiplying that product by the average alcohol content for liquor. That is, (category midpoint) x 1.5 x 0.4 = absolute alcohol content for drinks per occasion. Absolute alcohol consumption for the drinking period previous to intake was calculated following Khavari as:

$$Va = (Fu - Fm)\ Vu + (Fm)\ Vm$$

where Va = annual volume;

Fu = frequency usual,

Vu = volume usual,

Fm = frequency maximum

and Vm = volume maximum.

Chapter IV

Results

The data accumulated from the clients' pre- and post-tests were statistically analyzed in order to investigate differences on the DRIE, Bradburn and Khavari scales.

A. Data Analysis

The student "t" (two-tailed) test for differences between correlated means was employed to test differences in responses to items on the 3 scales. A Type I error rate of 0.01 was used because of the many tests carried out. In all cases, it appeared that the .01 level detected differences that were not only significant, but practical as well.

(i)Item Differences on the DRIE Scale The results for items on the DRIE Scale are shown in Table 7. There were 8 missing cases (N=26). Missing cases were those clients with incomplete data which also included those who did not complete the pre-test.

The findings and discussion on this scale are discussed in terms of items rather than the scale as a whole. These items ask questions which relate to the 3 critical factors identified by Donovan and O'Leary (1978). The factors are subsequently discussed.

Table 7.

Summary of Statistics for Outcome Variables: DRiE Scale*

Variable VARIABLE	NO. Of CASES	MEAN	STANDARD DEVIATION	DESCRIPTORS
pre-test item 1	26	2.81	0.85	helplessness
post-test		3.85	1.12	
pre-test item 2	26	3.81	0.94	breaks needed
post-test		4.31	0.88	
pre-test item 3	26	3.42	1.17	arguments cause drinking
post-test		4.19	0.90	
pre-test item 4	26	3.58	0.90	sobriety requires breaks
post-test		3.85	1.00	
pre-test item 5	26	3.35	1.20	see bottle, need drink
post-test		4.35	0.75	
pre-test item 6	26	3.70	0.84	others drive to drink
post-test		4.04	0.96	
pre-test item 7	26	3.15	1.31	parties cause drinking
post-test		4.04	0.87	
pre-test item 8	26	3.35	1.20	cannot resist a drink
post-test		4.23	0.65	
pre-test item 9	26	2.81	1.06	can't understand others' control
post-test		3.54	0.95	

*Significant at the $P<0.01$ level for items except 4 and 6.

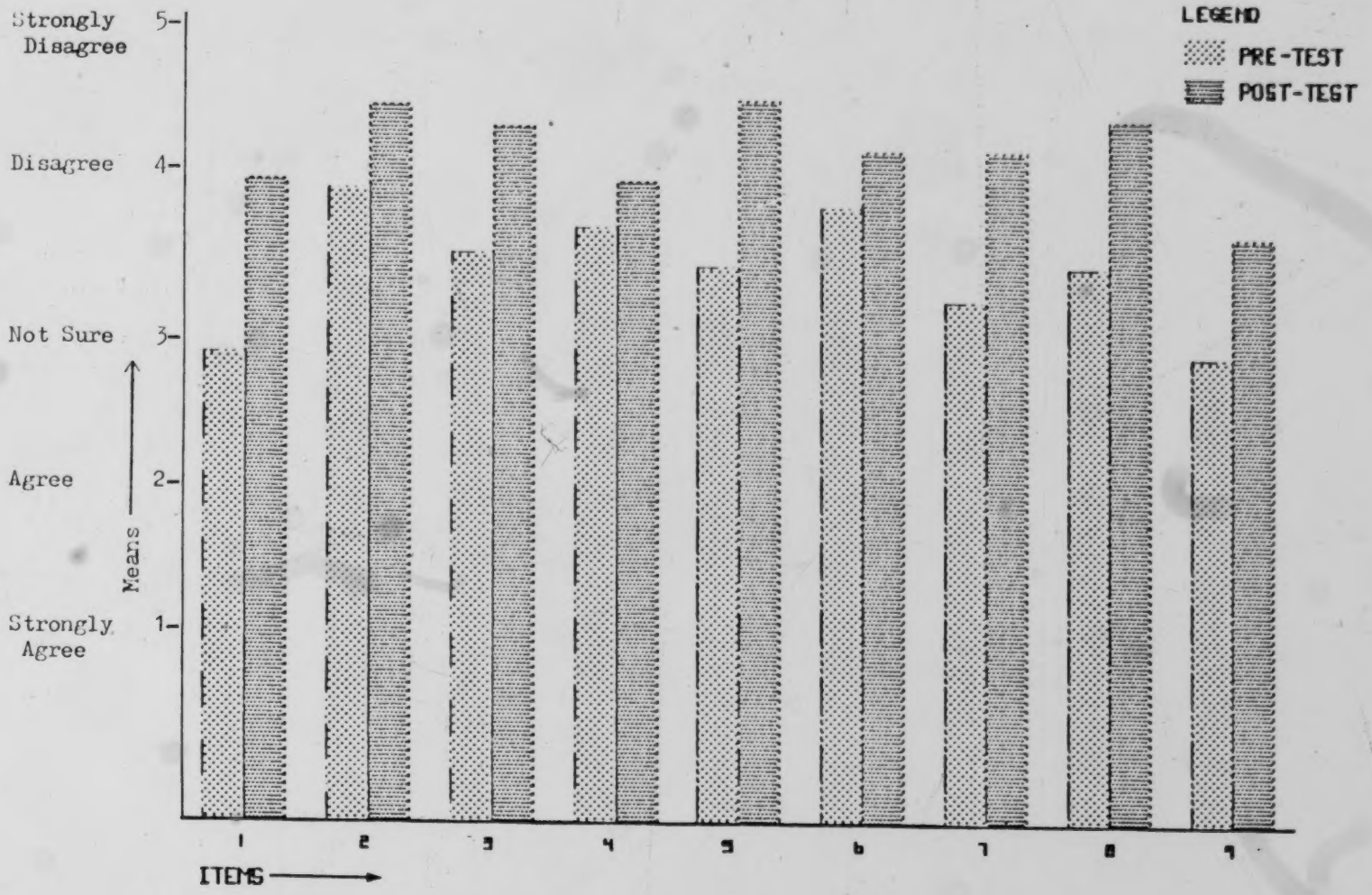

FIG. 4: PRE- AND POST-TEST MEANS FOR DRIE SCALE ITEMS

Findings: Means for 7 of the 9 items (except for 4 and 6) were significantly different and larger ($p<0.01$) (see Table7; Fig. 4). The largest shift in mean was for item 1 (1.04). The smallest, but significant, shift was for item 2 (0.50). In terms of Z-scores, these shifts correspond to 1.22 and 0.53 repectively (pre-test mean=Z=0).

Conclusion: The null hypothesis is rejected. There are significant differences between pre- and post-test means for items 1, 2, 3, 5, 7, 8 and 9 using DRIE.

Disussion: Using factor analysis, Donovan and O'Leary (1978) identified 3 main factors of the DRIE Scale: the Interpersonal, the General and the Intrapersonal Control Factors.

The Interpersonal Control Factor deals with the subject's inability to resist social or interpersonal pressures to drink, or an inability to manage anger or frustration provoking interpersonal situations. Items 1 (helplessness), 3 (agruments cause drinking) and 6 (other drive to drink) are associated with this factor.

The General Control Factor focuses on chance or unpredicatable events which influence the subject's drinking in general. Items 2 (breaks needed), 4 (sobriety requires breaks) and 9 (can't understand others' control) are related to this factor.

The Intrapersonal Control Factor is concerned with subject's apparent inability to resist the temptation to

drink. It is linked to his or her internal states, motivations, or drives (Walker, Nast, Chaney and O'Leary, 1979). Items 5 (see bottle, need drink), 7 (parties cause drinking) and 8 (cannot resist a drink) are associated with this factor.

From the result of the DRIE Scale, (that is, significant differences in means for items 1, 2, 3, 5, 7, 8 and 9 at the pre- and post-stages), the overall effect of treatment in subjects seems to be a shift in the direction of more internal control over their drinking behaviour.

This is consistent with the findings of other workers (Walker, Nast, Chaney and O'Leary, 1979; Walker, Van Ryn, Frederick, Reynolds and O'Leary, 1980) that there is a general shift from externality to internality on this scale over the duration of alcoholism treatment. This lends some support to the notion that the subject's increased ability to take responsibility for his actions (internality) is related to successful treatment outcome. However, one can speculate, based on insignificant results for items 4 and 6, that subjects still believe that staying sober depends on other events going right for them and that the power to control their drinking lies with others.

Furthermore, items 4 and 6 are the second and third highest items on the pre-test for the DRIE Scale. From the value of these 2 items, one can speculate that, in comparison to other items, subjects did not tend to believe that "sobriety required breaks" and that "other people drive

one to drink". This could be: (a) a statistical effect due to a limited scale range, or (b) a program effect: counsellors may have thought that most clients did not need to change much in these 2 areas. Alternatively, counsellors may have stressed change in other areas because they were already functioning adequately in these two areas.

The foregoing points have both theoretical and practical implications. For example, a future study can explore the difference between item 4 and item 6 and the other items of the scale in greater detail. In practice, group therapists at the WEC can place more emphasis, in doing group work, on issues related to items 4 and 6.

(ii)Item Differences on the Bradburn Affect-Balance Scale

The results of the Bradburn Scale are shown in Table 8. There were 4 missing cases (N=30). Missing cases were those who did not complete the scale and were thus omitted from the data.

Table 8

Summary of statistics for outcome variables: Bradburn Affect-Balance Scale*

VARIABLE	NO. OF CASES	MEAN	STANDARD DEVIATION	DESCRIPTORS
pre-test		2.40	0.72	
item 1	30			top of world
post-test		3.20	0.61	
pre-test		1.70	0.79	
item 2	30			lonely
post-test		2.53	0.82	
pre-test		2.70	0.75	
item 3	30			excited
post-test		3.33	0.66	
pre-test		1.63	0.81	
item 4	30			depressed
post-test		2.67	0.66	
pre-test		2.90	0.66	
item 5	30			pleased, accomplished
post-test		3.57	0.68	
pre-test		1.63	0.81	
item 6	30			bored
post-test		2.40	0.81	
pre-test		2.60	0.62	
item 7	30			proud
post-test		3.17	0.65	
pre-test		2.03	0.93	
item 8	30			restless
post-test		2.63	0.85	
pre-test		2.38	0.73	
item 9	29			things going (my) way
post-test		3.24	0.64	
pre-test		2.20	0.85	
item 10	30			upset
post-test		2.83	0.70	
pre-test		1.57	0.57	
item 11	30			overall
post-test		2.13	0.57	

*Significant at the $P<0.01$ level for all items.

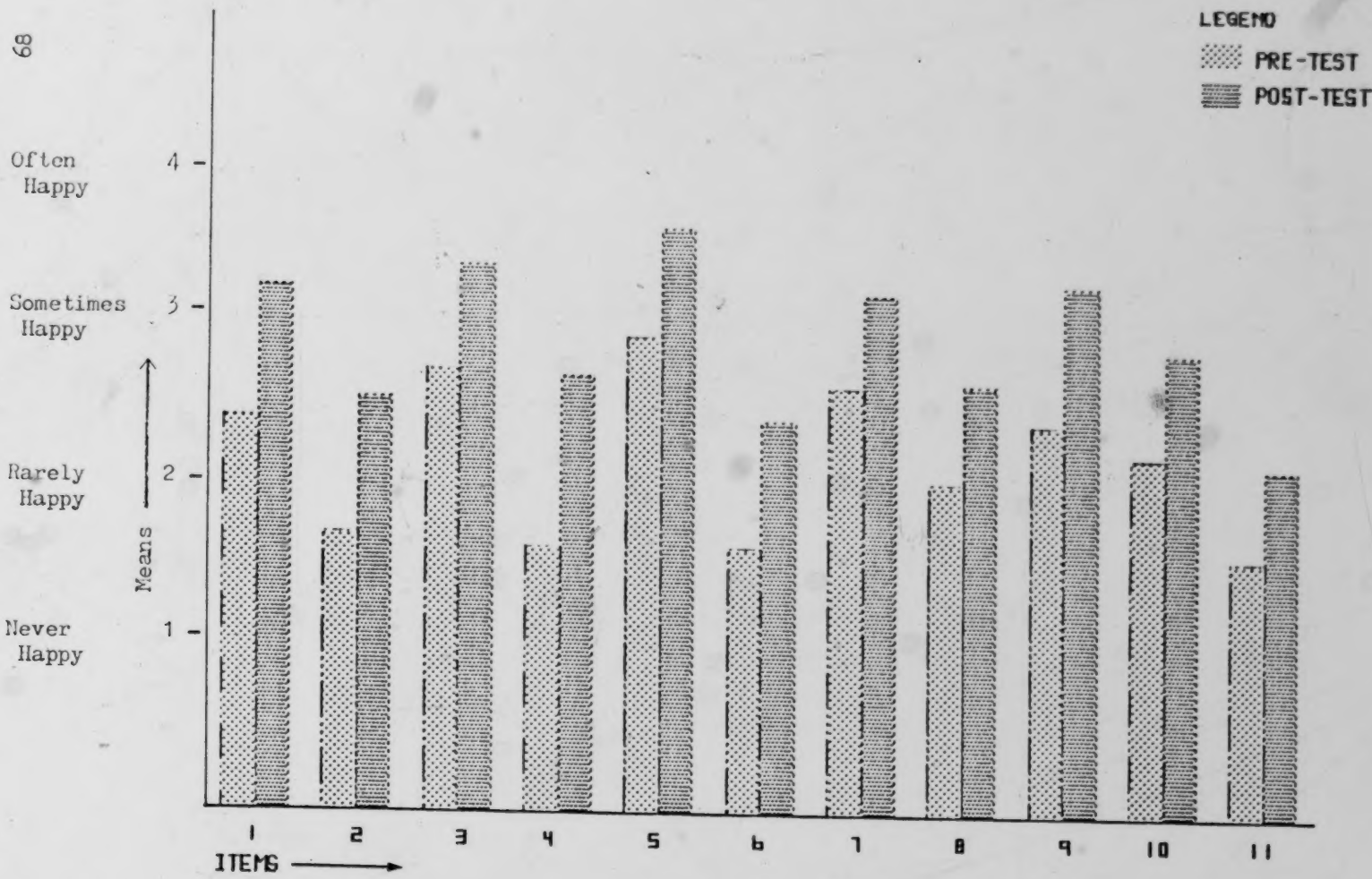

FIG. 5: PRE- AND POST-TEST MEANS FOR BRADBURN AFFECT-BALANCE SCALE ITEMS

Findings: For the 11 items on this scale, the original 10 plus 1 summary question, the outcome was significant for items ($p<0.01$) (see Table 8; Fig. 5). The largest shift in mean (1.04) was for item 4. The smallest shift (0.56) was for item 11. The highest pre- and post-test values, 2.90 and 3.57 repectively, was for item 5. Z-score shift for item 4 and 11 equal 1.28 and 0.98 respectively.

Conclusion: The null hypothesis is rejected. Pre- and post-test mean scores on the Bradburn items are significantly different as a result of treatment.

Discussion: With regard to the Bradburn items, the highest improvement was for item 4, which dealt with subjects' frequency of depression. This may be related to the fact that they drank less, as the results of the Khavari Alcohol Test indicates, along with concurrent improvements in other life areas.

Item 11 was a general question dealing with subjects' overall affective state. The small shift may be due ot the fact that only 3 rank orders were used on the Likert Scale for this item.

It would appear, based on the results for item 5 (pleased, accomplished), that subjects came into treatment with a high sense of competence. At follow-up, this had further improved.

(iii)Results for the Khavari Alcohol Test

The results for the Khavari Alcohol Test are shown in Table 9. There were 9 missing cases (N=25). Complete data were not available for these cases.

Table 9

Summary of statistic for outcome variable: Khavari Alcohol Test*

VARIABLE	NO. OF CASES	MEAN	STANDARD DEVIATION	DESCRIPTOR
pre-test volume	25	89.41	90.85	amount of absolute alcohol
post-test		19.77	59.28	

*Significant at the $p<0.01$ level for this item.

Absolute Amount of Alcohol/Drinking Occasion

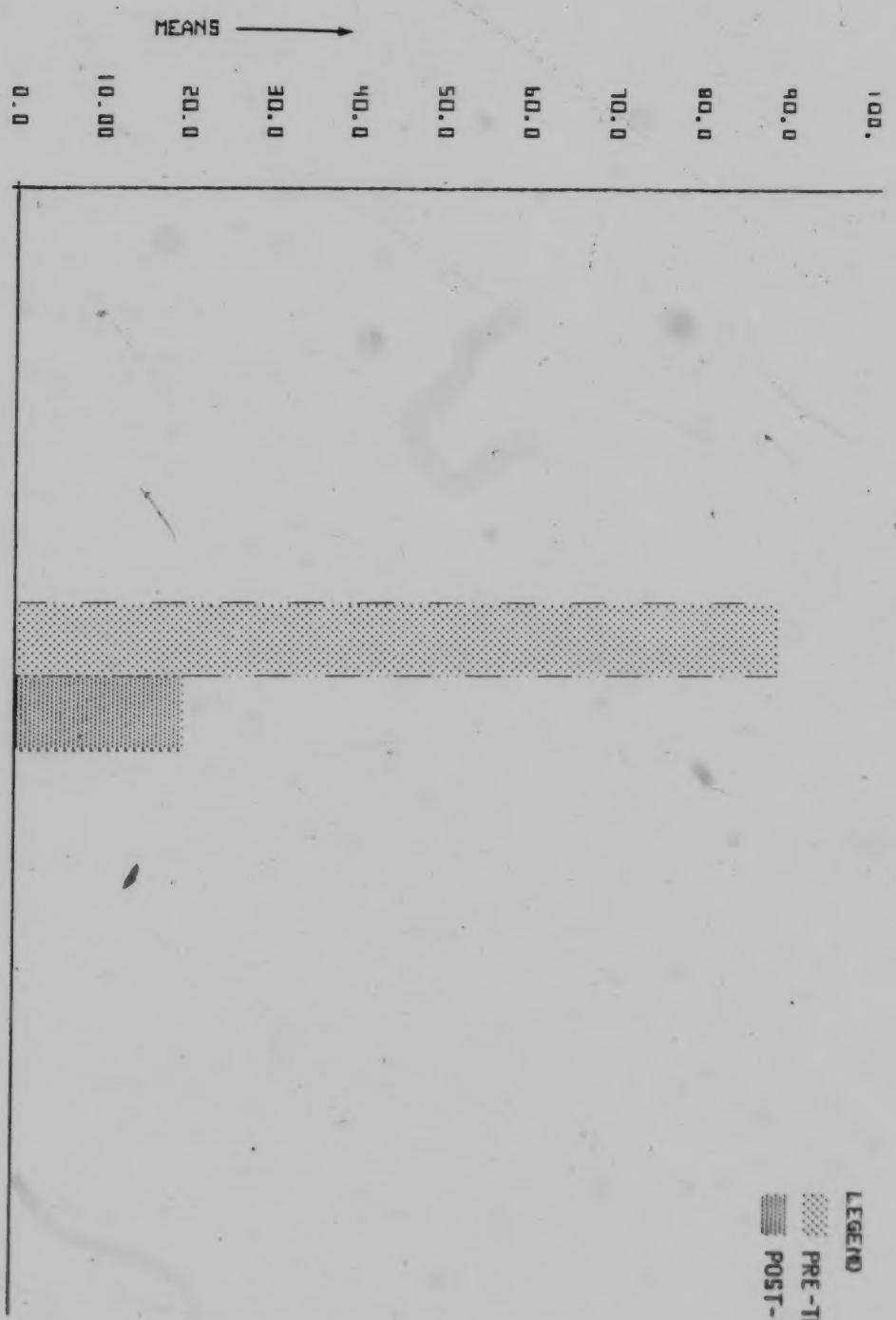

FIG. 6: PRE AND POST-TEST MEANS FOR KHAVARI ALCOHOL TEST

Findings: The mean score for the pre-test is 89.41, compared to 19.77 for the post-test (see Table 9; Fig. 6). The 69.94 discrepancy accounted for the significant change in the amount of alcohol comsumed by subjects.

Conclusion: The null hypothesis is rejected. There is a significant difference for the Khavari Alcohol Test scores from pre- to post-test.

Discussion: As the above results indicate, subjects consumed considerably less alcohol after treatment. At follow-up, 19 subjects were abstinent[1], 12 still drinking and there were 3 missing cases. The 19 cases should not necessarily be taken as the sole measure of treatment success. As Gerard and Saenger (1962, 1966) have pointed out, abstinent alcoholics may experience a variety of other problems, such as difficulties in marriage and jobs functioning, which may worse after they abstain from alcohol. Significant improvement in other areas of life functioning, such as self-satisfaction and relations with friends, should be considered as well. These are examined in the following section.

B. Additional Findings

In this study, the Z-test of proportions was used to determine statistically significant shifts for 6 other outcome variables. For each of these variables (see Table 10), subjects (N=34) were classified into two categories:

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[1] Abstinence was defined as no alcohol intake during the 3 months immediately prior to the follow-up contact.

those showing improvement or those not showing improvement. Frequency counts on the non-applicable categories were omitted. The data is presented in the table 10.

Table 10

Summary of Frequency Statistics for 6 other Outcome Variable (N=34)*

OUTCOME VARIABLES	CATEGORIES: NO IMPROVEMENT OBSERVED FREQUENCIES	CATEGORIES: IMPROVEMENT OBSERVED FREQUENCIES
Rating of physical health	1	28
Satisfaction with self	1	27
Satisfaction with social life	1	26
Satisfaction with use of spare time	2	20
Satisfaction with work	4	26
Relations with friends	0	34

*Significant at the $p<0.01$ level for all variables.

A sample calculation is shown for the variable "rating of physical health".

a) Null Hypothesis, H_0: $f_1=f_2$ (category frequencies are equal).

b) $\alpha = 0.01$ (i.e., the probability of Type I error).

c) N = 34, df = 1. Critical Z (1, N = 34) = 1.96, $p < .01$.

d) Using the formula:

$$Z_{obs.} = \sqrt{\frac{p - 0.5}{pq/n}}$$

n = N- # or non-applicable cases;
p = proportion improving;
and q = proportion not improving

$$Z_{obs.} = \sqrt{\frac{0.82 - 0.50}{\frac{(0.82)\ (0.03)}{29}}}$$

$$= 19.40 > 1.96.$$

Since $Z_{obs} > Z_{crit.}$, H_o is rejected. Improvement is significantly greater than would predicted by chance (0.5).

In conclusion, the post-treatment subject profile indicates that he or she has more control over drinking behaviour, consumes considerably less alcohol and is generally happier than before. The subject has improved relations with friends and enjoys better employment status. His or her physical health is improved. Furthermore, he or she is more satisfied with self, spare time use and social life.

Chapter V

Concluding Remarks

The purpose of the present study was to evaluate the impact of AADAC's West End Centre Treatment Program on specific areas of clients' (alcoholics) lives. Outcome effects were assessed by the following criteria:

(1) The degree to which clients were more internal on the DRIE Scale;

(2) the degree of satisfaction in clients' emotional well-being as measured by the Bradburn Happiness item;

(3) reduced alcohol consumption; and

(4) the degree to which other aspects of clients' lives (for example, satisfaction with self), had improved.

The main component of the Treatment Program was group therapy. A review of the literature indicates that comparatively few studies of group treatment with alcoholics have been conducted. Of these, some are inconclusive, whereas a few support the efficacy of group therapy in treating alcoholics.

For the 34 subjects who complete all phases of this study, the results suggest that outcome effects were generally favourable. Nevertheless, the fact that complete data were not available for 59.0% of subjects means that findings should be treated with some degree of caution.

On a final note, further study needs to be conducted to verify these findings and to examine the consolidation of treatment gains over a longer time period.

A. Sources of Error

Despite overall positive results, however, there were 6 identifiable sources of error in this study. Following Suchman (1967), three of these were:

(1) Other extraneous events may have occurred simultaneously with the treatment and thereby influence the outcome measure. For example, subjects may have felt physically better during the duration of treatment because of abstaining from alcohol. This might have been the key factor influence post-treatment drinking behaviour.

(2) The treatment effect may have been due to spontaneous remission. That is, some subjects may have improved with or without exposure to the treatment. Unstimulated change in these subjects may have been a function of time alone. Although exact figures for spontaneous remission among alcoholics in Canada are not available, it is likely that such figures may not be as high as for other conditions. Nevertheless, one can pose the question: Could treatment have affected the rate of spontaneous remission? No adequate answer to this question is presently available.

(3) The pre-test itself may be a stimulus for change as distinct form the impact of the treatment program.

Other sources of error include:

(4) Therapist expectation and values may have influenced the results. In particular, subjects may have answered the post-test according to therapist expectation

rather than providing answers that truly indicated changes on the given variables.

(5) Subjects' self-reports may have minimized the extent of their drinking. However, some investigators (for example, Sobell and Sobell, 1982) cite evidence to show that various populations of alcohol abusers usually report their drinking reliably and validly when they are sober and interviewed in a clinical setting.

(6) Finally, because of high subject attrition (59.0%), data on most subjects were not available. It is likely that those subjects who had better post-treatment outcome, as distinct from those with no change or change for the worse, volunteered for the post-test. This could positively bias the results. This point has been emphasized by some investigators, such as Moos and Bliss (1978) and Sobell and Sobell (1978). Better treatment outcome may be related to subjects' pre-treatment motivation to change.

To conclude, the results of this study generally support the effectiveness of group therapy as a treatment modality for alcoholism. However, as pointed out earlier, the alcoholic population is not homogeneous. Thus, more specialized research is needed in the area of group thereby with alcoholics. As Pattison (1965, 1970) indicated, what is lacking in this area is a clear differentiation of types of group methods which can be selectively used, for specific therapeutic goals, with different types of subjects.

However, the experimental design required to do this would require the use of a control group (no treatment condition) and the random assignment of subjects into groups (treatment condition). For ethical reasons, this is impractical because alcoholics are generally in a poor state physically and mentally at the time of referral. In the writer's opinion, subjects on a short-term waiting list can serve as controls, although this may not be feasible in most cases.

B. Recommendations

In light of the above discussion, the following recommendation are made:

1. Use of other sources of data.

   This study primarily utilized the self-report questionnaire method for data collection. The value of another method, such as reports from employers and spouses in addition to self-reports, should be explored.

2. Use of a larger sample.

   The conclusions from this investigation cannot be generalized beyond the specific setting and sample. It would be instructive to compare treatment outcome with a larger sample of subjects from a more diverse background.

3. Use of a longer follow-up interval.

   It would be interesting to use a longer (more than three months) follow-up interval. Sobell and Sobell

(1981) suggest a minimum of 12 months to assess pre-treatment variables. The writer concurs with these investigators. The rationale here is that 12 months may be an adequate period to consolidate treatment gains.

4. Multiple follow-up contacts instead of one.

It is likely that, in a prospective study, multiple follow-up contacts instead of one would decrease subject loss due to attrition (Søbell and Sobell, 1982). In the case of the WEC, subjects may be assessed at the termination of the Day Program and again periodic intervals, ranging from 3 months to 1 year.

5. More feedback from clients.

A fifth recommendation is that group therapists provide more opportunity for ongoing feedback from clients during group sessions. In the follow-interview conducted by the writer, subjects generally made positive comments about the competence of the therapists. However, they also expressed the belief that more open, direct and relevant feedback from group members, as distinct from the counsellor, would improve the quality and, thus, the effeciveness of future groups.

6. A similiar replicated study.

Another recommendation is to incorporate the above points in a similar replicated study. Such a study would:

a. use other sources of data besides clients' self-report

b. use a larger sample size;

c. employ a longer follow-up interval (minimum of 12 months);

d. utilize multiple follow-up contacts instead of one; and finally

e. modify group therapy sessions ot allow for more client participation.

7. Comparison with other programs.

A further recommendation is to compare the WEC Day Program with other treatment programs for alocoholics such as the Henwood Program' . An empirical study using a pre-post test design with same research instruments is suggested.

8. Use of an alternative research design.

Finally, in future alcohol program evaluation studies, an alternative approach such as the Recurrent Institutional Cycle Design (RICD) (Stanley and Campbell, 1966) may be used. RICD is more appropriate in situations in which a given aspect of an institutional process is continually being presented to a new group of subjects.

At the WEC, this design would allow for a number of simultaneous operations. For example, incoming subjects

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' Henwood Rehabilitation Centre is located in the north-eastern outskirts of the city of Edmonton. It conducts a 3-week inpatient program for substance-abusers. This program is similar to, but not identical with, the WEC Day Program.

can be randomly sampled to provide two groups -- an experimental, and a control group on a short-term waiting list (two weeks). Because there is overlap between the formation an termination of treatment groups, pre- and post-treatment tests may be conducted at the same time.

RICD may be schematically respresented as:

---------> T --------> R

Group I R_1 --------> T --------> R_2

Group II (C) ---------->R_3

where R = post--test of group completing treatment (T);
R_1 = pre--test for incoming Group I;
R_2 = post--test for Group I; and
R_3 = post--test for the control group (C).

A comparison between R_2 and R_3 will be subject to fewer sources of internal and external invalidity than the pre- and post-tests comparison employed in this study. However, because exact spontaneous remission figures for alcoholics are not known, the results of preliminary studies must be treated with some degree of caution.

References

AADAC, 1983. *Quick Facts Pamphlet*. Provincial Programs Division, Alberta.

Abbott, M.M., 1984. Locus of Control and Treatment Outcome in Alcoholics. *Journal of Studies on Alcohol*. 45(1). 46-52.

Addiction Research Foundation, 1976. *Information Review*. Toronto.

Albrecht, G.L., 1973. Alcoholism, progress and research treatment. In P.G. Bourne and R. Fox (Eds.), *Alcoholism - progress in research and treatment*. Academic Press. New York.

Ansel, J.C., 1984. Interpersonal dynamics of treatment of alcohol abuse. *Dissertation Abstracts International*. 45(4). 1276-B.

Alcoholics Anonymous: The Story of How Many Thousands of How Many Thousands of Men and Women Have Recovered from Alcoholism (new and revised ed.), 1955. Alcoholics Anonymous World Services: New York.

American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (DSM - III). 1980. 3rd ed.. Washington, D.C.

Bandura, A., 1969. *Principles of Behaviour Modification*. Holt, Reinhart and Winston. New York.

Benet, D., and Ditman, K.S., 1967. Tranquilizers in the management of alcoholics: A review of the literature to 1964. *Journal of Clinical Pharmacology*. 7. 17-25.

Berne, E., 1961. *Transaction Analysis in Psychotherapy*. Grove Press. New York.

Berne, E., 1964, *Games People Play*, Grove Press, New York.

Berne, E., 1966, *Principles of group treatment*, Oxford University Press, New York.

Blume, E.M., and Blum, R.H., 1967, *Alcoholism, Modern Psychological Approaches to Treatment*, Jossey-Bass Inc., San Francisco.

Blume, S.B., 1974, Psychodrama and alcoholism, *Annals of the New York Academy of Science, 233*, 123-127.

Blume, S.B., 1978, Group psychotherapy in the treatment of alcoholism. In *Practical Approaches to Alcoholism Psychotherapy*, Zimberg, S., Wallace, J., and Blume, S.B. (eds.), Plenum Press, New York.

Bradburn, N.M., and Caplovitz, D., 1965, *Reports on Happiness*, Aldine Publishing Company, Chicago.

Bradburn, N.M., 1969, *The Structure of Psychological Well-Being*, Aldine Publishing Company, Chicago.

Brunner-Orne, E.M., and Orne, M., 1954, Directive Group Therapy in the treatment of Alcoholics: Technique and Rationale, *International Journal of Group Psychotherapy, 4*, 272-279.

Burkhart, B.R., and Ratliff, K.G., 1984, Sex differences in motivations for and effects of drinking among college students, *Journal of Studies on Alcohol, 45*(1), 26-32.

Campbell, D.T., and Stanley, J.C., 1966, *Experimental and Quasi-experimental Designs for Research*, Houghton Mifflin Company, Boston.

Cahn, S., 1970, *The Treatment of Alcoholics: An Evaluation Study*, Oxford University Press, New York.

Catanzaro, R.J., (Ed.) 1968, *Alcoholism: The Total Treatment Approach*, C.C. Thomas, Springfield, Illinois.

Cronkite, R.C., and Moos, R.H., 1984, Sex and marital status in relation to the treatment and outcome of alcoholic patients, *Sex Roles*, *11* (1-2), 93-112.

Ditman, K.S., Review and evaluation of current drug therapies in alcoholism, 1966, *Psychosomatic Medicine*, *28*, 667-677.

Donovan, D.M., and O'Leary, M.R., 1978, The Drinking-related Locus of Control Scale (DRiE): reliability, factor structure and validity, *Quarterly Journal of Studies on Alcohol*, *39*, 759-784.

Doroff, D.R., 1977, Group psychotherapy in alcoholism, In Kissin, B., and Begleiter, H., eds., *Treatment and Rehabilitation of the Chronic Alcoholics*, Plenum Press, New York.

Ends, E.J., and Page, C.W., 1957, A Study of three types of group psychotherapy with hospitalized male inebriates, *Journal of Studies on Alcohol*, *18*, 267-277.

Ends, E.J., and Page, C.W., 1959, Group psychotherapy and concomitant psychological changes, *Psychological Monographs*, *73* (10), 1-31.

Evseeff, G.S., 1948, Group psychotherapy in a state hospital, *Diseases of the Nervous System*, *9*, 214-218.

Feibel, C., 1960, The archaic personality structure of alcoholics and its indications for group therapy, *International Journal of Group Psychotherapy*, *10*, 39-45.

Forrest, G.G., 1978, *The Diagnosis and Treatment of Alcoholism*, Charles C. Thomas, Springfield, Illinois.

Fox, R., 1962, Group psychotherapy with alcoholics, *International Journal of Group Psychotherapy*, *12*, 56-63.

Gerard, D.L., Saenger, G. and Wile, R., 1962, The Abstinent Alcoholic, *Archives of General Psychiatry*, *6*, 83-95.

Gerard, D.L., Saenger, G., 1966, *Outpatient Treatment of Alcoholism*, University of Toronto Press, Toronto.

Glasser, W., 1965, *Reality Therapy: A new approach to psychiatry*, Harper and Row, New York.

Gottheil, E., McLellan, A.T., and Druley, K.A. (eds.), 1981, *Matching Patient Needs and Treatment Methods in Alcoholism and Drug Abuse*, C.C. Thomas, Springsfield, Illinois.

Greenbaum, H., 1954, Group psychotherapy with alcoholism in conjunction with Antabuse treatment, *International Journal Group Psychotherapy*, *4* (30), 30-45.

Health and Welfare Canada, and Statistics Canada, 1981,*The Health of Canadians, Reports of the Canada Health Survey*, Minister of Supply and Services Canada, Ottawa.

Health and Welfare Canada, and Statistics Canada, 1984, *Alcohol in Canada. A National Perspective*, Prepared by the Working Group on Alcohol Statistics, Ottawa.

Hill, M.J., and Blane, H.T., 1967, Evaluation of Psychotherapy with alcoholics: A critical review, *Quarterly Journal of Studies on Alcohol*, *28*: 76-104.

Hoffman, H., Noem, A.A., and Petersen, D., 1975, Treatment effectiveness as judged by successfully and unsuccessfully treated alcoholics, *Drug and Alcohol Dependence*,*1*, 241-246.

Jellinek, E.M., 1960, *The Disease Concept of Alcoholism*, Hillhouse Press, New Haven.

Kanas, N., 1982, Multifactor Group Therapy for Alcoholics, *Current Psychiatric Therapies*, 149-153.

Khavari, K.A., and Farber, P.D., 1978, A Profile Instrument for the Quantification and Assessment of Alcohol Consumption, *Journal of Studies on Alcohol*, *39* (9), 1525-1539.

Kissin, B., 1977, Theory and practice in the treatment of alcoholism, in Kissin, B., and Begleiter, H (eds.): *The Biology of Alcoholism, Vol. 5: The Treatment and Rehabilitation of the Chronic Alcoholic*, Phenum Press, New York.

Kissin, B., Rosenblatt, S., and Machover, S., 1968, Prognostic factors in al alcoholism. In Cole, J.O., (ed.) *Clinical Research in Alcoholism*, American Psychiatric Association, Washington, D.C.

Kivlahan, D.R., Donovan, D.M., and Walker, R.D., 1983, Predictors of Relapse: Interaction of Drinking-Related Locus of Control and Reasons for drinking, *Addictive Behaviours*, *8* (3), 273-276.

Kramer, J.F., and Cameron, D.C., (eds.), 1975, *A Manual on Drug Dependence*, World Health Organization, Geneva.

Ludwig, A.M., and Wilker, A., 1974, "Craving" and relapse to drink, *Quarterly Journal of Studies on Alcohol*, *35*, 108-130.

Macdonald, J.G., 1983, Role of personal networks in the recovery from alcoholism, *Dissertation Abstracts International*, *44*(03), 865-A.

Martensen-Larsen, O., 1956, Group psychotherapy with alcoholics in private practice, *Internation Journal of Group Psychotherapy*, *6*, 28-37.

McGinnis, C.A., 1963, The effect of group therapy on the ego-strength scale scores of alcoholic patients, *Journal of Clinical Psychology*, *19*, 346-347.

Miller, P.M., 1972, The use of behavioural contracting in the the treatment of alcoholism: A case report, *Behaviour Therapy*, *3*, 593-596.

Miller, P.M., Dvorak, B.A. and Turner, D.W., 1960, A method of Creating Aversion to Alcohol by Reflex Conditioning in a Group Setting, *Journal of Studies on Alcohol*, *21*, 424-431.

Miller, P.M., Herson, M., Eisler, R.M., and Hemphill, D.P., 1973, Electrical aversion therapy with alcoholics: An analogue study, *Behaviour Research Therapy*, *11*, 491-497.

Moreno, J.L., 1946,*Psychodrama*, *1*, Bacon House, New York.

Moos, R., and Bliss, F., 1978, Difficulty of follow-up and outcome of alcoholism treatment, *Journal of Studies on Alcohol*, *39*, 473-490.

Mullan, H., and Sanguiliano, I., 1966, Alcoholism: *Group Psychotherapy and Rehabilitation*, Charles C. Thomas, Springfield, Illinois.

Nerviano, V.J., and Gross, W.F., 1976, Loneliness and locus of control for alcoholic males: validation against Murray need and Cattell trait dimensions, *Journal of Clinical Psychology*, *32*, 479-484.

Oziel, L.J., and Obitz, F.W., 1975, Control Orientation in alcoholics related to the extent of treatment, *Quarterly Journal of Studies on Alcohol*, *36*, 158-161.

Oziel, L.J., and Obitz, F.W., and Keyson, M., 1972, General and specific perceived locus of *Psychological Reports*, *30*, 957-958.

Pattison, E.M., 1965, Evaluation of group psychotherapy, *International Journal of Group Psychotherapy*, *15*, 382-397.

Pattison, E.M., 1970, Group psychotherapy and group methods in community mental health programs, *International Journal of Group Psychotherapy*, *20*, 516-539.

Pattison, E.M., Sobell, M.B., and Sobell, L.C., 1977, *Emerging Concepts of Alcohol Dependence*, Springer Press, New York.

Perls, F., 1973, *The Gestalt Approach and eye witness to therapy*, Bantam, New York.

Perls, F., Hefferline, R., and Goodman P., 1951, *Gestalt Therapy: Excitement and growth in the human personality*, Dell, New York.

Rogers, C., 1951, *Client-centered Therapy*, Houghton Miffin, Boston.

Rogers, C., 1961, *On becoming a person*, Houghton Miffin, Boston.

Rohsenow, D.J., and O'Leary, M.R., 1978, a, Locus of Control research on alcoholic population: a review Development, scales and treatment, *International Journal of the Addictions*, *13*, 55-78.

Rohsenow, D.J. and O'Leary, M.R., 1978, b, Locus of Control research on alcoholic , *International Journal of the Addictions*, *13*, 213-226

Rotter, J.B., 1966, Generalized Expectatancies for internal versus external control of reinforcement. *Psychological Monographs*, *80*, No. 1. (Whole No. 609).

Rotter, J.B., 1975, Some problems and misconceptions to the construct of internal versus external control of reinforcement, *Journal of Consulting and Clinical Psychology*, *43*, 56-67.

Seevers, M.H., 1968, Psychopharmacological elements in drug dependence, *Journal of American Medical Association*, *206*: 1263-1266.

Sobell, M.B., and Sobell, L.C., 1978, *Behavioural Treatment: Individualized Therapy and Controlled Drinking*, Plenum, New York.

Sobell, M.B. and Sobell, L.C., 1973, Individualized behaviour therapy for alcoholics, *Behaviour Therapy*, *4*, 49-72

Sobell, L.C., and Sobell, M.B., 1981, Outcome Criteria and the Assessment of Alcohol Treatment Efficacy, In National Institute on Alcohol Abuse and Alcoholism Research Monograph No. 5, *Evaluation of the Alcoholic:*

Implications for research, theory, and treatment, U.S. Government Printing Office, Washington, D.C.

Sobell, L.C., and Sobell, M.B., 1982, In Alcoholism Treatment Outcome Evaluation Methodology, National Institute on Alcohol Abuse and Alcoholism, Alcohol and Health Monograph No. 3, *Prevention, intervention and treatment: concerns and models*, National Institute on Alcohol Abuse and Alcoholism, Washington, D.C.

Stein, A., and Friedman, E., 1971, Group therapy with alcoholics. In *Comprehensive Group Therapy*, Kaplan, H.I., and Sadock, B.J., (eds.), Williams and Wilkins, Baltimore.

Steiner, C.M., 1971, *Games Alcoholics Play*, Grove Press, New York

Suchman, E.A., (1967), *Evaluative Research*, Russell Sage Foundation, New York.

Tiebout, H.M., 1962, Intervention in psychotherpy, *American Journal of Psychoanalysis, 33*, 1-6.

Viamontes, J.A., 1972, Review of drug effectiveness in the treatment of alcoholism, *American Journal of Psychiatry, 128*, 1570-1571.

Walker, R.D., Nast, E.C., Chaney, E.F., and O'Leary, M.R., 1979, Changes in drinking related locus of control as a function of length of alcoholism treatment *Psychological Reports, 44*, 287-293 .

Walker, R.D., Van Ryn, F., Frederick, B., Reynolds, D. and O'Leary, M.R., 1980, *Psychological Reports, 47*, 871-877.

Wolff, K., 1968, Hospitalized alcoholic patients: III. Motivating alcoholics through group psychotherapy, *Hospital and Community Psychiatry, 19*, 206-209.

Yalom, I.D., 1975, *The Theory and Practice of Group Psychotherapy*, Basic Books, New York.

Yalom, I.D., Bloch, S., Bond, G., Zimmerman, E., and Qualls, B.,1978, Alcoholics in Interactional Group Therapy, An Outcome Study, *Archives of General Psychiatry, 35,* 419-425.

Zimberg, S., Wallace, J., and Blume, S.B., (Eds.), 1978, *Practical Approaches to Alcoholism Psychotherapy,* Plenum Press, New York.

APPENDIX A

ORIENTATION DAY FORMAT

ORIENTATION DAY FORMAT

Day : Friday

Place: Impaired Driver's Room

Times:

10:00 - 10:50	Welcome to W.E.C. Explanation of Day Program content Explanation of Group Therapy Expectations of clients in Day Program and group therapy - attendance, participation, confidentiality, etc. Counsellor's role as facilitator.
10:50 - 11:05	Break
11:05 - 12:00	Mini lecture on Defense mechanisms Video of W.E.C. staff Client's observations of defenses and group dynamics.
12:00 - 1:00	Lunch.
1:00 - 2:15	Introduction film, "I'll Quit Tomorrow" (Reel #1) - brief reference to progression of alcoholism - mood swings and effects on others - defense mechanisms to be observed. Film, "I'll Quit Tomorrow" Discussion - highlights of film.
2:15 - 2:30	Questionnaire (W.E.C. study) - clients to fill out
2:30 - 2:45	Break
2:45 - 3:45	Personal introductions
3:45 - 4:00	Wrap up - ascertaining clients' commitment for next two weeks - stressing attendance, honesty, etc. - stress A.A. attendance and AADAC resources.

APPENDIX B

LECTURE SERIES CONTENT

LECTURE - A NEW LOOK AT CHEMICAL DEPENDENCIES

KEY CONCEPTS	LEARNING OBJECTIVES	LEARNING FORMAT	RESOURCES UTILIZED	TIME REQUIRED	TOPIC AREA
Uncertainty as to "Why".	1. To stop trying to figure out why they abuse. 2. To deal with their lives "now".	Lecture - Questions and Answers (Large group)	Diagram - Blackboard Handouts - wheel compare AA & AADAC	2.5 hours (Ideally)	Mental-Educational Approach.
Addiction is a disease.	1. To accept themselves with a disease which can be treated.				
Disease affecting whole person.	1. To consider all aspects of life as they've been affected by the disease.				
Six life powers affected.	1. To be able to name the six life powers 2. To know what constitutes each life power.				
Need for change in all six areas for healing to occur.	1. To ascertain what and how they want to make changes in their lives.				
Two essentials for living wholly: a. Quit using M.A.D. b. Practice 12 Step Program.	1. To know the two essential means for achieving wholeness. 2. To recognize the importance of their need for a 12 Step Program.				

RELATED TOPICS

Nutrition	Group therapy - share thoughts, share feelings
Self-Esteem	AA - spiritual
Physical Effects	Goals? - social aspect

WHAT IS ADDICTION (DISEASE CONCEPT OF ALCOHOL)

KEY CONCEPTS

To provide an understanding as to the relationship of a disease or illness as applied to addiction

Disease or illness of any nature if not controlled will eventually cause suffereing, pain, and death

LEARNING OBJECTIVE

Increase awareness and understanding of the progressive nature of addiction.

RESOURCES UTILIZED

- Flip Chart
- Film (Father Martin's Guidelines)
- Chart (Progressive Steps to Alcoholism)
- Discussion

TIME REQUIRED

½ hr. lecture, flipchart
½ hr. film

10 minute coffee break
20 minute chart
½ hr. discussion

TOPIC AREA

Physical

LECTURE - EFFECTS ON RELATIONSHIPS

KEY CONCEPTS

Addiction affects everyone close to the dependent person.

Alcohol/drug dependence as the source of the problem.

Unwritten/unspoken rules preventing problem acknowledgement and action.

All family members suffer.

Lack of family communication.

Roles which children adopt in attempts to cope.

LEARNING OBJECTIVES

To understand that everyone close to the dependent person is affected by the addiction.

To recognize alcohol or drug use as the cause of the dysfunctional system.

To understand some unspoken rules that exist within the family unit which prevent acknowledgement of the problem.

To understand sources of family miscommunication.

To understand the effects of alcoholism on children.

LEARNING FORMAT

Lecture and discussion in large group.

RESOURCES UTILIZED

Film: A. If You Loved Me

or

B. Soft Is The Heart of A Child

- Flip Chart
- Some writing on Blackboard.

Could be put on overheads.

Handouts.

TIME REQUIRED

Lecture and discussion - 45 minutes

Film A. 1 hr.
B. ½ hr.

TOPIC AREA

-emotional
- mental
- social

RELATED TOPICS

- Ties in with goals and lifestyle
- Relapse prevention
- Communication
- Assertiveness

LECTURE - DRUGS AND DEPENDENCY

KEY CONCEPTS

To provide information which will lead to an understanding of the process of dependency.

To familiarize with the terminology used in drug abuse field in a positive way.

To familiarize participants that alcohol is also a drug.

To provide information on drugs and the principles of how they work.

LEARNING OBJECTIVES

Utilization of individual perception re: drug abuse in general and discussion to apply and improve understanding of process of dependency.

Through lecture and film, improve participants' knowledge re: classification of drugs and their effects on human beings.

LEARNING FORMAT

Large group

Open Questions and answer

Discussion/comments

Individual concerns re: specific drugs

RESOURCES UTILIZED

Hand Out

Flip Chart

Film (Psychoactive)

TIME REQUIRED

1 hour lecture

10 minutes coffee break

25 minutes film

25 minutes open discussion re: handouts, etc.

TOPIC AREA

Physical/Emotional

RELATED TOPICS

Cross tolerance
Withdrawal

LECTURE - EFFECTS OF ALCOHOL ON THE BODY

KEY CONCEPTS

Alcohol is a depressant drug.

Alcohol travels through the body in the bloodstream.

Tolerance: increasing amounts of alcohol for the same effect.

Withdrawal: body's attempts to re-adjust to an alcohol-free state.

Nature of delirium tremens.

Short-term physical affects:
- increased heart rate
- warm feeling
- increased production of digestive juices.
- increased output of urine
- loss of appetite

Short term behavioural effects:
- increased talk
- depression
- slurred speech
- blurred vision & depth perception.
- poor muscle control
- loss of muscular coordination
- blackouts

LEARNING OBJECTIVES

To show that alcohol is a drug with both physical and mental effects.

To detail the above effects.

LEARNING FORMAT

Lecture, questions and answers.

Discussion.

Comments.

RESOURCES UTILIZED

Blackboard.

Film: "Alcohol You".

TIME REQUIRED

1½ - 2 hrs.

TOPIC AREA

Physical.

Emotional.

KEY CONCEPTS - Con't

Long-term effects, physical & behavior:
- chronic laryngitis
- ulcers (esophagus)
- gastritis
- duodenal ulcers
- jaundice
- hepatitis
- cirrhosis
- Wernicke's disease
- Korsakoff's disease

RELATED TOPICS

Effects on the family.

Role of nutrition.

Effects on lifestyle.

LECTURE - SELF-ESTEEM

KEY CONCEPTS	LEARNING OBJECTIVES	LEARNING FORMAT	RESOURCES UTILIZED	TIME REQUIRED	TOPIC AREA
To provide participants with an opportunity to develop skills in recognizing conscious and subconscious state of awareness of their feelings and self-esteem.	Utilization of individual perception re: self image, self-esteem to apply and improve individual understanding of self-esteem through discussion and encourage them to take risks and be more assertive socially and emotionally more expressive.	- Lecture - Large Group - Open Questions and answer - Discussion/ Comments - Sharing	- Handouts - Diagrams - Film (Optional)	1 hour lecture 10 minutes coffee break ½ hour lecture 20 minutes discussions and sharing time re: handouts.	- Emotional - Social
To provide an opportunity to examine their own behavior and actions towards self or others.	Utilization of hand out and encourage discussion and give them exercises to take home and practice assertive behaviour and be able to recognize and discriminate between passive and aggressive behaviour.				
To provide them an opportunity to share their own self-esteem and feelings in a non-threatening environment and stress the focus on self rather than on others.	Through discussion and sharing, provide them skills to build their positive self-esteem.				
Encourage them to take responsibility of their own feelings, self-esteem, stress, needs, expectations and behaviour.					
Allow them to be more assertive, self-confident and independent in making decisions and take responsibility of their own decisions and responses in a human interaction.	Participants should be able to recognize that self-esteem is a life long process and needs continual efforts on their part.				

RELATED TOPICS

- Assertive Behaviour
- Passive Behaviour
- Communication
- Aggressive Behaviour

LECTURE - "RELAPSE PREVENTION"

KEY CONCEPTS	LEARNING OBJECTIVES	LEARNING FORMAT	RESOURCES UTILIZED	TIME REQUIRED	TOPIC AREA
Factors leading to relapse.	To provide information concerning the major factors leading to relapse.	Lecture Large group discussion. Questionnaire	Flipchart Blackboard Film (New Life of Sandra Blaine)	1 hour for lecture, questionnaire, and discussion plus 1 hour for film and discussion.	Combines all of them, probably emphasizing mental and volitional
Major causes of relapse.	To increase client s awareness of their own high risk situations.				
High risk situations.	To provide an opportunity for clients to develop and discuss an anticipatory plan of action for their own high risk situations.				
Balanced support system.	To discuss possible reactions to a slip; to explore alternative methods of preventing slips from snowballing.				
Anticipatory plan of action.					
Preventing slips from snowballing.					

RELATED TOPICS

"Best" before: Effects on Relationships

"Best" after: Goals and Lifestyle/A.A.

IDEAS

To include "hurdles" information in form of a graph.

To try out the plan-of-action in "real life."

LECTURE - GOALS AND LIFESTYLE CHANGE

KEY CONCEPTS	LEARNING OBJECTIVES	LEARNING FORMAT	RESOURCES UTILIZED	TIME REQUIRED	TOPIC AREA
Lifestyle as unique combination of patterns of habits and routines controlling life.	To understand that one's lifestyle is made up of your own pattern of habits, roles and routines.	Lecture	Handout "Operation Lifestyle". Black Board.	15 minutes	Physical Social Emotional Mental
Need to change parts of lifestyle contributing to the problem(s).	To understand that you can control alcohol/drug problems if you change supporting habits, roles and routines.	Lecture and discussion and assignment	Back side of handout. Blackboard.	30 minutes	
Change process involves decision-making and goal-setting.	To pinpoint the roles, habits and routines that contribute to the problems and then set goals that will develop more appropriate habits, etc	Lecture, discussion	Flip Chart, diagrams		
Basic human needs met by recreation and leisure activities.	To see how leisure activities meet basic human needs such as affection, fun, confidence and importance.	Lecture, discussion	Car analogy, Blackboard.		
Importance in sobriety of a balanced leisure activity program.	To see that leisure activities can meet the same human needs as alcohol/drugs.	See #4.	See #4.		
Leisure Counselling.	To understand the need for leisure counselling.	Lecture, discussion	Blackboard.		

RELATED TOPICS

Prevention of relapse/
self esteem

Effects on Relationships

APPENDIX C

RELAXATION TECHNIQUES

RELAXATION TECHNIQUES

I. Introduction

Each of us has periods in our lives when we must deal with stressful situations. As well, we all have different methods for coping with this stress. It is when we are unable to adequately cope with stress that we get into trouble.

Our bodies react to stress as a poison that must come out. If we hold this tension inside, we may experience such physical discomforts as headaches, stomach pain, ulcers, diarrhea, or constipation. One healthy way of dealing with tension is to talk about the situation(s).

Relaxation therapy really means self-relaxation. It is a way of learning to be aware of the tension we experience in the different parts of our body and to train ourselves to relieve this tension by relaxing.

We will try to attain relaxation through a sequence of tensing particular muscle groups one at a time, followed by the relaxation of the muscle group. The first few times you practise self-relaxation, you may experience very little relaxation. However, through practise you should be able to experience total relaxation. As you become more proficient at self-relaxation, you will be able to relax by concentrating on the feeling of relaxation you have previously experiencedin each muscle group.

There are a few guidelines to follow before and while doing relaxation therapy.

1. You should preferably lie on the floor with a pillow or sit in a well-supported chair.
2. Find a comfortable position. It is best not to have the legs crossed. Arms should be either at the sides or folded across the abdomen.
3. Close your eyes and concentrate on what you are doing. If you wear glasses, you should remove them.

4. Loosen any restricting clothing; ties, belts, shoes...
5. Put out your cigarette. It is a good idea to stop smoking about one half hour before relaxation therapy.
6. If you feel like coughing or sneezing, do not suppress it. If you do suppress it, it will cause more muscular tension.

Practise Relaxation Techniques everyday. It will be more beneficial to you if you do.

II. The Relaxation Technique

As soon as you are in a comfortable position, have a good stretch. We will start the exercise, as usual, with a couple of deep breathing exercises. Take a good deep breath, breathing in through your mouth and expanding your lungs and chest fully. Then blow out all the air. Repeat this several times.

Now let us work with the muscles of the right hand and forearm. Clench your right fist! Feel the tension in the fingers, the hand, and forearm. Concentrate only upon the tension in the muscles and hold it while counting slowly to 5. Then just relax, letting the muscles go completely loose, completely limp, and free of all tension. Feel the difference as the muscles relax completely. Breathe evenly, easily, and just relax while counting to 10 slowly.

Moving now to the muscles of the right upper arm, bend your right arm sharply at the elbow. Feel the pull of the muscles in the right biceps and upward toward the right shoulder. Hold it and count slowly to 5. Once again, just relax. As the muscles relax, feel the tension leaving. Let us move to the muscles of the left hand and forearm. Clench your left fist! Feel the tension in the fingers, hand, and forearm. Concentrate only upon the tension in these muscles and hold it while counting to 5. Now relax, let the muscles go completely loose, completely limp, and free of all tension. Feel the difference as the muscles relax completely. Breathe

evenly, easily, and relax. Count to 10 slowly.

Now let us move to the muscles of the left upper arm. Bend the left arm sharply at the elbow. Feel the pull of the muscles in the left bicep and upwards toward the left shoulder. Hold this position for 5 counts. Once again, relax. Feel the difference as the muscles relax, completely free of all tension. Count slowly to 10.

Move now to the heavy muscles of the shoulders, the muscles across the shoulder blades, and the muscles at the base of the neck. If you are sitting up, hunch your shoulders sharply upward toward your ears and lower your chin. If you are lying down, raise the points of the shoulders slightly from the carpet and lower your chin. Feel the pull of the muscles in the shoulders, across the shoulder blades, and at the base of the neck. Hold this position while you slowly count to 5. Once again, just relax. Feel the difference as the muscles relax completely, free of all tension. As always, breathe evenly and easily, smoothly and regularly. Just relax and count to 10.

For those of you who may be troubled by headaches, we will now move to the forehead. Frown hard! Wrinkle your forehead! Feel the tension in your forehead and upward into your scalp. Hold it and count to 5 slowly. Just relax and feel the difference as the muscles relax completely. Count slowly to 10.

Now move to the muscles around your eyes, the bridge of your nose, and your upper cheeks. Close your eyes tightly and wrinkle your nose. Feel the tension in the muscles around the eyes, across the nose, and in the upper cheeks. Concentrate only upon the tension in these muscles and hold it, while counting slowly to 5. Then just relax. Feel the difference as the muscles relax completely. Breathe evenly and easily and just relax. Again count to 10.

Now let us move to the muscles of your cheeks, jaw, and the muscles in front of the throat. Clench your teeth tightly together and tuck your chin in slightly. Feel the tension in the muscles of the

cheeks, the jaw, and the front of the throat. Concentrate only on the tension in the muscles as you count to 5 slowly. Now, let the muscles go completely loose and free of all tension. Breathe easily and evenly and just relax. Count to 10 slowly.

Move now to the muscles of your chest, the upper sides, and muscles across the upper back. Tighten these muscles by inhaling. Feel the pull of the muscles in the chest, the upper sides, and upper back. Concentrate only upon the tension in these muscles and hold it for 5 slow counts. As before, just relax. Let the muscles go completely loose and free of all tension, while breathing evenly and easily. Relax! Count to 10 slowly.

By now all the muscles of the right hand and arm, the left hand and arm, and the muscles of the shoulders, shoulder blades, neck, face, and chest are completely at ease. Your mind should be completely at rest, free of all worry. Just follow my voice, breathe evenly and easily, and just relax.

We will now move to the muscles of the abdomen, the lower sides, and the lower back. Tighten these muscles by pressing outward on the stomach muscles. Feel the pull of the muscles across the abdomen, around the lower sides, and across the lower back. Concentrate only upon the tension in these muscles and hold it, once again for 5 counts. Then relax. Feel the tension leaving as the muscles relax completely. Remember to breathe evenly and easily and just relax. Count to 10 slowly.

Let us go on to the muscles in the right upper leg, the calf of the leg, the foot, and the toes. If you are sitting up, press down hard with your right foot. If you are lying down, arch your right foot downward, and arch the toes upward toward the body. Feel the tension in the right upper leg, the calf of the leg, and the foot, and toes. Concentrate only upon the tension in these muscles and hold it. Count to 5 slowly. As before, just relax; feel the relaxation flowing from the right upper leg, downward through the calf, into the foot and

and into the toes. Feel the difference as these muscles relax completely. Count to 10 slowly. Just breathe evenly and easily, and just relax.

Move now to the muscles in the left upper leg, the calf of the leg, the left foot, and the toes. If you are sitting up, press down hard with your left foot. If you are lying down, arch your left foot downward, and arch the toes upward toward the body. Feel the tension in the left upper leg, the calf of the leg, and the left foot and toes. Concentrate only upon the tension in these muscles and hold it. Count to 5 slowly. And as before, just relax, feel the relaxation flowing from the left upper leg downward through the calf, into the foot, and into the toes. Feel the difference as these muscles relax completely. Count to 10 slowly. And again, remember to breathe evenly and easily. Just relax.

By now, all the muscles of the right and left hands and arms, the shoulder muscles, the muscles of the face, chest, and back, are completely relaxed. The muscles of the right and left upper legs, the calves of the legs, the feet, and the toes are completely at ease. Your body is warm and comfortable, completely relaxed. Your mind should be completely at rest, and free of all worry, as you simply follow my voice. Relax and do nothing. Just breathe evenly and easily, smoothly and regularly, and just relax. Count to 10 slowly.

I will end the exercise with the count of four. At the count of four, open your eyes. Sit up slowly to prevent any dizziness. Flex your arms a couple of times. Do this on your own time. There is no hurry. 1 - 2 - 3 - and - 4. The exercise is now complete.

APPENDIX D

RESEARCH INSTRUMENT #1

AADAC ADMISSION/DISCHARGE FORM

IDENTIFICATION

SURNAME | GIVEN NAMES | HOME PHONE | TREATY OR DISC. NUMBER | BAND NAME

ADDRESS | BUSINESS PHONE | 1. ALBERTA HEALTH CARE

NEAREST RELATIVE OR FRIEND | RELATIONSHIP | 2. OTHER PROVINCE HEALTH CARE

ADDRESS | PHONE | (SPECIFY) | LENGTH OF RESIDENCE

ADMISSION DATA

1. AADAC IDENTIFIER | 2. AGE | 3. AGENCY NUMBER | 4. ADMISSION DATE DAY MONTH YEAR

5. NUMBER OF ADMISSIONS

6. TYPE OF REFERRAL SOURCE (CHECK ONE)
- 01 ☐ OUTPATIENT CLINIC (AADAC)
- 02 ☐ RES. TREATMENT CENTRE (AADAC)
- 03 ☐ DETOX CENTRE (AADAC)
- 04 ☐ JUDICIAL / CORRECTIONS
- 05 ☐ PROBATION
- 06 ☐ DRIVER CONTROL BOARD
- 07 ☐ POLICE
- 08 ☐ HOSPITAL
- 09 ☐ PHYSICIAN
- 10 ☐ EMPLOYER
- 11 ☐ AA / AL-ANON / AL-ATEEN
- 12 ☐ PRIVATE AGENCY
- 13 ☐ GOV'T AGENCY
- 14 ☐ RELATIVE / FRIEND
- 15 ☐ SELF
- 16 ☐ AGENCIES FUNDED BY AADAC
- 18 ☐ LAWYER
- 19 ☐ SCHOOL
- 17 ☐ OTHER (SPECIFY) _____

6a. NAME OF REFERRAL SOURCE

7. PREVIOUS AADAC TREATMENT
1 ☐ YES 2 ☐ NO 3 ☐ UNKNOWN

7a. IF YES, SPECIFY MOST RECENT (CHECK ONE)
- 1 ☐ OUTPATIENT _____
- 2 ☐ INPATIENT _____
- 3 ☐ DETOX _____

8. CURRENT MARITAL STATUS
- 01 ☐ SINGLE
- 02 ☐ MARRIED
- 03 ☐ SEPARATED
- 04 ☐ DIVORCED
- 05 ☐ WIDOWED
- 06 ☐ COMMON LAW

9. EDUCATION GRADE

10. POST SECONDARY EDUCATION
- 1 ☐ VOCATIONAL TRAINING
- 2 ☐ SOME TECHNICAL SCHOOL
- 3 ☐ TECHNICAL SCHOOL DIPLOMA
- 4 ☐ SOME UNIVERSITY/COLLEGE
- 5 ☐ UNIVERSITY/COLLEGE DEGREE
- 6 ☐ OTHER (SPECIFY) _____
- 7 ☐ NONE

11. CURRENT EMPLOYMENT STATUS
- 1 ☐ UNEMPLOYED
- 2 ☐ EMPLOYED FULL TIME /SELF
- 3 ☐ EMPLOYED PART TIME/CASUAL
- 4 ☐ RETIRED
- 5 ☐ HOUSEWORKER
- 6 ☐ STUDENT
- 7 ☐ OTHER (SPECIFY) _____

12. OCCUPATION CODE

13. PRESENTING CLIENT
1 ☐ SELF 2 ☐ PRIMARY COLLATERAL 3 ☐ SECONDARY COLLATERAL

13a. PRESENTING COLLATERAL
- 1 ☐ SPOUSE
- 2 ☐ CHILD
- 3 ☐ FRIEND
- 4 ☐ EMPLOYER
- 5 ☐ OTHER

14. ADMITTED FOR? (CHECK ONE)
- 1 ☐ REGULAR TREATMENT
- 2 ☐ FOLLOWUP PROGRAM
- 3 ☐ INFORMATION ONLY
- 4 ☐ UNCERTAIN

15. PRESENTING DRUG PROBLEM
1 ☐ SINGLE 2 ☐ DUAL 3 ☐ POLY

15a. MAJOR DRUG(S) ABUSED

	PRIMARY (CHECK ONE)	SECONDARY (CHECK ONE IF NEEDED)
ALCOHOL	1 ☐	1 ☐
HEROIN/OPIATES	2 ☐	2 ☐
HALLUCINOGENS	3 ☐	3 ☐
MARIJUANA/HASHISH	4 ☐	4 ☐
TRANQUILIZERS	5 ☐	5 ☐
BARBITURATES	6 ☐	6 ☐
AMPHETAMINES	7 ☐	7 ☐
SOLVENTS	8 ☐	8 ☐
OTHER (SPECIFY) _____	9 ☐	9 ☐

16. OTHER DRUGS

NOTES/REMARKS

FORM COMPLETED BY

DISCHARGE DATA

1. DATE OF LAST TREATMENT DAY MONTH YEAR | 2. TIME PERIOD IN TREATMENT DAYS | 3. NUMBER OF VISITS

4. REASON FOR SEPARATION (CHECK ONE)
- 1 ☐ TREATMENT COMPLETED
- 2 ☐ CLIENT TRANSFERRED
- 3 ☐ TREATMENT TERMINATED BY CLIENT
- 4 ☐ TREATMENT TERMINATED BY STAFF
- 5 ☐ ASSESSED ONLY

5. REFERRED TO: (CHECK UP TO THREE)
- 01 ☐ OUTPATIENT CLINIC (AADAC)
- 02 ☐ RES. TREAT. CENTRE (AADAC)
- 03 ☐ DETOX CENTRE (AADAC)
- 04 ☐ PHYSICIAN
- 05 ☐ HOSPITAL
- 06 ☐ EMPLOYER
- 07 ☐ AA/AL-ANON/AL-ATEEN
- 08 ☐ PRIVATE AGENCY
- 09 ☐ GOV'T AGENCY
- 10 ☐ PROBATION/CORRECTION INST.
- 12 ☐ AGENCIES FUNDED BY AADAC
- 11 ☐ NOT REFERRED
- 13 ☐ OTHER (SPECIFY) _____

6. NAME OF REFERRAL TARGET

7. NUMBER OF OTHER PEOPLE INVOLVED IN TREATMENT

NOTES / REMARKS

FORM COMPLETED BY

D 04522

APPENDIX E

RESEARCH INSTRUMENT #2

CLIENT SELF-ADMINISTERED PRE-TEST

WEST END CENTRE STUDY

Name: _____

1. In general, how would you rate your physical health over the past three months?

Very Poor	Poor	Fair	Good	Very Good
☐	☐	☐	☐	☐

2. Here is a list that describes some of the ways people feel at different times. Please check the **one** response that most closely describes your feelings. **During the past three months**, how often have you felt...

	Often	Sometimes	Rarely	Never
A. On top of the world?	☐	☐	☐	☐
B. Very lonely or remote from other people?	☐	☐	☐	☐
C. Particularly excited or interested in something?	☐	☐	☐	☐
D. Depressed or very unhappy?	☐	☐	☐	☐
E. Pleased about having accomplished something?	☐	☐	☐	☐
F. Bored?	☐	☐	☐	☐
G. Proud because someone complimented you on something you had done?	☐	☐	☐	☐
H. So restless you couldn't sit long in a chair?	☐	☐	☐	☐
I. That things were going your way?	☐	☐	☐	☐
J. Upset because someone critized you?	☐	☐	☐	☐

Taking things all together, how would you say things are these days - would you say you're:	Very Happy	Pretty Happy	Not Too Happy
	☐	☐	☐

3. How satisfied have you been with **yourself** over the **past three months**?

Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied
☐	☐	☐	☐	☐

4. How satisfied have you been with **your social life** (your friends, activities, spare time), over the **past three months**?

Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied
☐	☐	☐	☐	☐

5. Would you say you used your spare time very well, well, fair, poor or very poor?

Very Well	Well	Fair	Poor	Very Poor
☐	☐	☐	☐	☐

6. In general, how satisfied have you been with your ability to do your job (or school work or housework if you are a student or housewife) in **the past three months**?

Does Not Apply	Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied
☐	☐	☐	☐	☐	☐

7. **Over the past three months**, how well would you say you got along with:

	Does Not Apply to Me	Very Poorly	Poorly	Fair	Well	Very Well
Your Parents	☐	☐	☐	☐	☐	☐
Your Spouse	☐	☐	☐	☐	☐	☐
Your Child or Children	☐	☐	☐	☐	☐	☐
Your Brothers or Sisters	☐	☐	☐	☐	☐	☐
Your Friends	☐	☐	☐	☐	☐	☐
Your Employer	☐	☐	☐	☐	☐	☐
The people You Work With	☐	☐	☐	☐	☐	☐

8. **In the past three months**, how often have you:

	Not At All	Less Than Once A Month	1-3 Times A Month	Once A Week	More Than Once A Week
Attended A.A. Meetings	☐	☐	☐	☐	☐
Visited an Addiction Clinic	☐	☐	☐	☐	☐
Seen a psychiatrist or psychologist	☐	☐	☐	☐	☐
Seen a Social Worker for Counselling (not for Child Welfare or Financial Assistance)	☐	☐	☐	☐	☐
Attended church	☐	☐	☐	☐	☐
Attended meetings of self-help groups other than A.A.	☐	☐	☐	☐	☐

9. When you came to the West End Centre, were you concerned about your drinking?

Yes	No	-- IF NO, Go to Question 15.
☐	☐	

10. When did you **last drink an alcoholic beverage even if it was just a small amount?**

1 Day Ago	2-3 Days Ago	4-6 Days Ago	1-3 Weeks Ago	1 Month Ago	2-5 Months Ago	6 or More Months Ago
☐	☐	☐	☐	☐	☐	☐

11. How often did you **usually** drink alcoholic beverages **in the three months before your last drink?**

Less than One Day per Month	One Day Per Month	1-3 Days per Month	1-3 Days per Week	4-6 Days per Week	7 Days per Week
☐	☐	☐	☐	☐	☐

12. **For this question, one drink means 1 1/2 ounces of liquor or one bottle of beer or three ounces of port or sherry or five ounces of table wine.**

During the three months before your last drink, how many drinks did you **usually have on each drinking occasion.**

1 Drink per occasion	2-5 drinks per occasion	6-11 drinks per occasion	12-17 drinks per occasion	18 or more drinks per occasion
☐	☐	☐	☐	☐

13. A. **During the three months before your last drink,** what was the **most** you drank **on any single day?**

1 Drink	2-5 Drinks	6-11 Drinks	12-17 Drinks	18 Or More Drinks
☐	☐	☐	☐	☐

18 drinks is about 1 bottle of liquor or 1 1/2 cases of beer or 3 1/2 bottles of table wine or 2 bottles of sherry or port.

13 B. How many times did you drink that much or nearly that much in the three months before your last drink?

Less Than One Day Per Month	One Day Per Month	1-3 Days Per Month	1-3 Days Per Week	4-6 Days Per Week	7 Days Per Week
☐	☐	☐	☐	☐	

14. How much do you agree or disagree with each of the following statements?

A. I feel so helpless in some situations that I need a drink.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

B. Without the right breaks one cannot stay sober.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

C. I get so upset over small arguments that they cause me to drink.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

D. Staying sober depends mainly on things going right for you.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

E. When I see a bottle, I cannot resist taking a drink.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

F. Often times, other people drive one to drink.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

14. How much do you agree or disagree with each of the following statements? (Continued)

G. It is impossible for me to resist drinking if I am at a party where others are drinking.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

H. I feel completely helpless when it comes to resisting a drink.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

I. Sometimes I cannot understand how people can control their drinking.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

15. When you came to the West End Centre were you concerned about your use of drugs?

Yes	No -- IF NO, Go to Question 17
☐	☐

16. A. When did you last use the drugs that you are concerned about, **even if it was just a small amount?**

1 Day Ago	2-3 Days Ago	4-6 Days Ago	1-3 Weeks Ago	1 Month Ago	2-5 Months Ago	6 or More Months Ago
☐	☐	☐	☐	☐	☐	☐

B. On the average, how often have you used drugs like sleeping pills, diet pills, pills for nerves or depression, valium, librium, and so on **for medical reasons for the three months before you last used drugs?**

Less than One Day per Month	One Day per Month	1-3 Days per Month	1-3 Days per Week	4-6 Days per Week	7 Days per Week
☐	☐	☐	☐	☐	☐

16. C. On the average, how often have you used any kind of drug for non-medical reasons for the three months before you last used drugs?

Less than One Day per Month	One Day per Month	1-3 Days per Month	1-3 Days per Week	4-6 Days per Week	7 Days per Week
☐	☐	☐	☐	☐	☐

17. Please use this space to explain your answers if you think they need explaining.

_____

_____

_____

_____

_____

18. Please use space to add any other comments you want to make about yourself, the West End Centre, AADAC or this questionnaire.

_____

_____

_____

_____

_____

APPENDIX F

RESEARCH INSTRUMENT #3

COUNSELLOR'S PRE-TEST ASSESSMENT FORM

WEST END CENTRE STUDY

Please fill this form out for each client after you have gone through the Assessment Interview with the client.

AADAC IDENTIFIER

Relationships

1. Please rate the client's relations with the following over the past three months:

	Does Not Apply	Very Poor	Poor	Fair	Good	Very Good
Parents	☐	☐	☐	☐	☐	☐
Spouse	☐	☐	☐	☐	☐	☐
Child or Children	☐	☐	☐	☐	☐	☐
Brothers and/or Sisters	☐	☐	☐	☐	☐	☐
Friends	☐	☐	☐	☐	☐	☐
Employer	☐	☐	☐	☐	☐	☐
Fellow Employees	☐	☐	☐	☐	☐	☐

2. Please rate how much of the client's leisure time is spent in alcohol-dependent and/or drug dependent situations.

All Of The Time ☐ ☐ ☐ Half Of The Time ☐ ☐ ☐ None Of The Time

3. Please rate the extent to which the client's drug/alcohol problem has impaired his or her work performance (for students, use school performance and use housework for homemakers), over the past three months.

Does Not Apply	Severe Impairment	Some Impairment	Minor Impairment	No Impairment
☐	☐	☐	☐	☐

4. Overall, how would you rate the client's recognition of his or her positive characteristics.

Very Aware	Aware	Neutral	Unaware	Very Unaware
☐	☐	☐	☐	☐

5. Overall, how would you rate the client's recognition of his or her negative characteristics.

Very Aware	Aware	Neutral	Unaware	Very Unaware
☐	☐	☐	☐	☐

Rationality

6. Please rate the client's emotional functioning on the following.

	No Problems	Minor Problems	Moderate Problems	Severe Problems
Depression	☐	☐	☐	☐
Restlessness	☐	☐	☐	☐
Ability to Complete Tasks/ Projects	☐	☐	☐	☐
Interest in Other People	☐	☐	☐	☐
Sensitivity to Criticism	☐	☐	☐	☐

Physical Health

7. Please rate the client's physical health.

Very Poor	Poor	Fair	Good	Very Good
☐	☐	☐	☐	☐

8. Does the client have an alcohol problem?

Yes	No	- Go To Question 16
☐	☐	

9. When did the client last drink alcohol (even a small amount)?

1 Day Ago	2-3 Days Ago	4-6 Days Ago	1-3 Weeks Ago	1 Month Ago	2-5 Months Ago	6 Or More Months Ago
☐	☐	☐	☐	☐	☐	☐

Usual Alcohol Pattern

10. Based on your assessment interview with the client, please estimate the **average** number of days per month on which the client has had one or more drinks **during the three months prior to his or her last drink.**

Less than One Day Per Month	One Day Per Month	1-3 Days Per Month	1-3 Days Per Week	4-6 Days Per Week	7 Days Per Week
☐	☐	☐	☐	☐	☐

11. **For that period,** please estimate the number of drinks that the client usually had on each drinking occasion.

One Drink Per Time	2 to 5 Drinks	6 to 11 Drinks	12 or 17 Drinks	18 or More Drinks
☐	☐	☐	☐	☐

12A **During that period,** what was the **most** the client drank on **any single day?**

One Drink Per Time	2 to 5 Drinks	6 to 11 Drinks	12 or 17 Drinks	18 or More Drinks
☐	☐	☐	☐	☐

12B **During that period,** on how many days did the client drink that much alcohol or nearly that much alcohol?

Less than One Day Per Month	One Day Per Month	1-3 Days Per Month	1-3 Days Per Week	4-6 Days Per Week	7 Days Per Week
☐	☐	☐	☐	☐	☐

13. Overall, how would you rate the client's ability to resist drinking where alcohol is available?

Very Strong	Strong	Neutral	Weak	Very Weak
☐	☐	☐	☐	☐

14. Overall, how would you rate the client's ability to deal with stress that promotes drinking?

Very Strong	Strong	Neutral	Weak	Very Weak
☐	☐	☐	☐	☐

15. Overall, how would you rate the client's belief that "fate" or "chance" controls his or her drinking behavior?

Very Strong Belief in Fate	Strong Belief	Some Belief	Weak Belief	Very Weak Belief in Fate
☐	☐	☐	☐	☐

16. Does the client have a problem with drugs other than alcohol?

Yes	No	- Go To Question 20
☐	☐	

17. When did the client last use drugs (even a small amount)?

1 Day Ago	2-3 Days Ago	4-6 Days Ago	1-3 Weeks Ago	1 Month Ago	2-5 Months Ago	6 Or More Months Ago
☐	☐	☐	☐	☐	☐	☐

18. **In the three months before the client's last drug use**, please estimate the number of days on which the client used drugs **for medical reasons.**

Less than One Day Per Month	One Day Per Month	1-3 Days Per Month	1-3 Days Per Week	4-6 Days Per Week	7 Days Per Week
☐	☐	☐	☐	☐	☐

19. **In that period**, please estimate the number of days on which the client used drugs **for non-medical** reasons.

Less than One Day Per Month	One Day Per Month	1-3 Days Per Month	1-3 Days Per Week	4-6 Days Per Week	7 Days Per Week
☐	☐	☐	☐	☐	☐

20. Comments about the client _____

_____

_____

_____

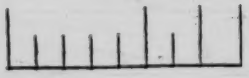
_____

_____

APPENDIX G

RESEARCH INSTRUMENT #4

CLIENT SELF-ADMINISTERED POST-TEST

WEST END CENTRE FOLLOW-UP 

1. Here is a list that describes some of the ways people feel at different times. Please check the **one** response that most closely describes your feelings. **During the past three months**, how often have you felt...

	Often	Sometimes	Rarely	Never
A. On top of the world?	☐	☐	☐	☐
B. Very lonely or remote from other people?	☐	☐	☐	☐
C. Particularly excited or interested in something?	☐	☐	☐	☐
D. Depressed or very unhappy?	☐	☐	☐	☐
E. Pleased about having accomplished something?	☐	☐	☐	☐
F. Bored?	☐	☐	☐	☐
G. Proud because someone complimented you on something you had done?	☐	☐	☐	☐
H. So restless you couldn't sit long in a chair?	☐	☐	☐	☐
I. That things were going your way?	☐	☐	☐	☐
J. Upset because someone critized you?	☐	☐	☐	☐

	Very Happy	Pretty Happy	Not Too Happy
Taking things all together, how would you say things are these days - would you say you're:	☐	☐	☐

2. In general, how would you rate your physical health over the past three months?

Very Poor	Poor	Fair	Good	Very Good
☐	☐	☐	☐	☐

3. How satisfied have you been with yourself over the past three months?

Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied
☐	☐	☐	☐	☐

4. How satisfied have you been with your social life (your friends, activities, spare time), over the past three months?

Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied
☐	☐	☐	☐	☐

5. Would you say you used your spare time very well, well, fair, poorly, or very poorly?

Very Well	Well	Fair	Poorly	Very Poorly
☐	☐	☐	☐	☐

6. In general, how satisfied have you been with your ability to do your job (or school work or housework if you are a student or housewife) in the past three months?

Does Not Apply	Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied
☐	☐	☐	☐	☐	☐

7. Over the past three months, how well would you say you got along with:

	Does Not Apply to Me	Very Poorly	Poorly	Fair	Well	Very Well
Your Parents	☐	☐	☐	☐	☐	☐
Your Spouse	☐	☐	☐	☐	☐	☐
Your Child or Children	☐	☐	☐	☐	☐	☐
Your Brothers or Sisters	☐	☐	☐	☐	☐	☐
Your Friends	☐	☐	☐	☐	☐	☐
Your Employer	☐	☐	☐	☐	☐	☐
The People You Work With	☐	☐	☐	☐	☐	☐

8. In the past three months, how often have you:

	Not At All	Less Than Once A Month	1-3 Times A Month	Once A Week	More Than Once A Week
Attended A.A. Meetings.	☐	☐	☐	☐	☐
Visited an Addiction Clinic.	☐	☐	☐	☐	☐
Seen a psychiatrist or psychologist.	☐	☐	☐	☐	☐
Seen a Social Worker for Counselling (not Child Welfare or Financial Assistance).	☐	☐	☐	☐	☐
Attended church.	☐	☐	☐	☐	☐
Attended meetings of self-help groups other than A.A.	☐	☐	☐	☐	☐

9. In the past three months, how often have you felt:

	Often	Sometimes	Rarely	Never
Like someone was giving you a lot of hassles?	☐	☐	☐	☐
Angry because things weren't going your way?	☐	☐	☐	☐
Like life was being unfair to you?	☐	☐	☐	☐
Like you needed a drink or drugs to deal with physical withdrawal?	☐	☐	☐	☐
Like a drink or drugs would help to deal with some sort of pain?	☐	☐	☐	☐
Like drinking or using drugs to celebrate a holiday or special occasion.	☐	☐	☐	☐
Like trying drinking or drugs just to see if anything would happen.	☐	☐	☐	☐
Like drinking or using drugs when the urge just came out of nowhere.	☐	☐	☐	☐

10. When you came to the West End Centre, were you concerned about your drinking?

Yes	No	-- IF NO, Go to Question 15.
☐	☐	

11. Have you had a drink since you left the West End Centre program?

Yes	No	-- IF NO, Go to Question 16.
☐	☐	

12. When did you last drink an alcoholic beverage even if it was just a small amount?

1 Day Ago	2-3 Days Ago	4-6 Days Ago	1-3 Weeks Ago	1 Month Ago	2-5 Months Ago	6 or More Months Ago
☐	☐	☐	☐	☐	☐	☐

13. How often did you usually drink alcoholic beverages in the three months before your last drink?

Less than One Day per Month	One Day Per Month	1-3 Days per Month	1-3 Days per Week	4-6 Days per Week	7 Days per Week
☐	☐	☐	☐	☐	☐

14. For this question, one drink means 1 1/2 ounces of liquor or one bottle of beer or three ounces of port or sherry or five ounces of table wine.

During the three months before your last drink, how many drinks did you usually have on each drinking occasion.

1 Drink per occasion	2-5 drinks per occasion	6-11 drinks per occasion	12-17 drinks per occasion	18 or more drinks per occasion
☐	☐	☐	☐	☐

15. A. During the three months before your last drink, what was the most you drank on any single day?

1 Drink	2-5 Drinks	6-11 Drinks	12-17 Drinks	18 Or More Drinks
☐	☐	☐	☐	☐

18 drinks is about 1 bottle of liquor or 1 1/2 cases of beer or 3 1/2 bottles of table wine or 2 bottles of sherry or port.

15. B. How many times did you drink that much or nearly that much in the three months before your last drink?

Less Than One Day Per Month	One Day Per Month	1-3 Days Per Month	1-3 Days Per Week	4-6 Days Per Week	7 Days Per Week
☐	☐	☐	☐	☐	☐

16. How much do you agree or disagree with each of the following statements?

A. I feel so helpless in some situations that I need a drink.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

B. Without the right breaks one cannot stay sober.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

C. I get so upset over small arguments that they cause me to drink.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

D. Staying sober depends mainly on things going right for you.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

E. When I see a bottle, I cannot resist taking a drink.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

F. Often times, other people drive one to drink.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

17. How much do you agree or disagree with each of the following statements? (Continued)

G. It is impossible for me to resist drinking if I am at a party where others are drinking.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

H. I feel completely helpless when it comes to resisting a drink.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

I. Sometimes I cannot understand how people can control their drinking.

Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

18. When you came to the West End Centre were you concerned about your use of drugs?

Yes	No -- IF NO, Go to Question 17
☐	☐

19. Have you used any drugs since you finished the West End Centre Program?

Yes	No -- IF NO, Go to Question 20.
☐	☐

20. A. When did you last use the drugs that you are concerned about, even if it was just a small amount?

1 Day Ago	2-3 Days Ago	4-6 Days Ago	1-3 Weeks Ago	1 Month Ago	2-5 Months Ago	6 or More Months Ago
☐	☐	☐	☐	☐	☐	☐

20. B. On the average, how often have you used drugs like sleeping pills, diet pills, pills for nerves or depression, valium, librium, and so on **for medical reasons for the three months before you last used drugs**?

Less than One Day per Month	One Day per Month	1-3 Days per Month	1-3 Days per Week	4-6 Days per Week	7 Days per Week
☐	☐	☐	☐	☐	☐

C. On the average, how often have you used **any** kind of drug **for non-medical reasons for the three months before you last used drugs**?

Less than One Day per Month	One Day per Month	1-3 Days per Month	1-3 Days per Week	4-6 Days per Week	7 Days per Week
☐	☐	☐	☐	☐	☐

21. Please use this space to explain your answers if you think they need explaining.

22. Please use space to add any other comments you want to make about yourself, the West End Centre, AADAC or this questionnaire.

APPENDIX H

RESEARCH INSTRUMENT #5

COUNSELLOR'S POST-TEST ASSESSMENT FORM

WEST END CENTRE STUDY 1984

QUESTIONNAIRE (R'S)

Date: _____

QUESTIONNAIRE (R's)

FIRST, I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT HOW YOU HAVE BEEN DOING SINCE YOU WERE AT THE WEST END CENTRE. FOR MOST OF THE QUESTIONS, I'LL ASK YOU TO PICK ONE CHOICE FOR YOUR ANSWER. FOR OTHER QUESTIONS, I'LL WRITE DOWN YOUR ANSWER.

1. A. HAVE YOU LIVED AT YOUR PRESENT ADDRESS CONTINUOUSLY SINCE YOU WERE AT THE WEST END CENTRE?

   1. _____ Yes. If YES, Note Type Of Residence. _____ Go To 2.
   2. _____ No. If NO, Then Ask Part B.

   B. AFTER LEAVING THE WEST END CENTRE, WHAT WAS YOUR FIRST PLACE OF RESIDENCE WHERE YOU STAYED SEVEN OR MORE DAYS?

   1. _____ Apartment Or House
   2. _____ Hotel, Rooming/Boarding House
   3. _____ Hospital
   4. _____ In-patient Community
   5. _____ Jail Or Prison
   6. _____ Halfway House
   7 _____ Dormitory (eg. School Or Army)
   8. _____ No Fixed Address
   9. _____ Other, Please Explain _____

2. ARE YOU PRESENTLY:

   1. _____ Single
   2. _____ Married
   3. _____ Separated
   4. _____ Divorced
   5. _____ Widowed
   6. _____ Living Common-Law

3. ARE YOU, PRESENTLY:

1. _____ Unemployed
2. _____ Employed Full-Time
3. _____ Employed Part-Time
4. _____ Retired
5. _____ A Houseworker
6. _____ A Student
7. _____ Other, (Please Explain) _____

4. HAVE YOU SEEN A DOCTOR FOR A MEDICAL EXAMINATION OVER THE PAST THREE MONTHS?

1. _____ Yes
2. _____ No

5. A. HOW OFTEN DO YOU EXERCISE?

1. _____ Never - Go To Question 6
2. _____ A Few Times A Month
3. _____ About Once A Week
4. _____ A Few Times A Week
5. _____ Nearly Every Day
6. _____ Once A Day Or More

5. B. WHAT TYPE OF EXERCISE DO YOU DO? _____

_____

6. HOW ADEQUATELY DO YOU FEEL YOU CURRENTLY LOOK AFTER YOUR OWN HEALTH CARE NEEDS?

1. _____ Very Inadequately
2. _____ Inadequately
3. _____ Neutral
4. _____ Adequately
5. _____ Very Adequately

7. ARE YOU TAKING -- OR HAVE YOU TAKEN ANTABUSE SINCE LEAVING THE WEST END CENTRE?

1. _____ Yes
2. _____ No

8. IN YOUR OPINION, HOW RELAXED ARE YOU THESE DAYS?

1. _____ Very Relaxed
2. _____ Somewhat Relaxed
3. _____ Neutral
4. _____ Somewhat Tense
5. _____ Very Tense

9. A. WERE YOU TAUGHT ANY YOGA OR RELAXATION TECHNIQUES WHILE YOU WERE AT THE WEST END CENTRE?

1. _____ Yes
2. _____ No - Go To Question 10

9. B. DO YOU CURRENTLY USE ANY OF THOSE TECHNIQUES?

1. _____ No - Do Not Use
2. _____ Yes Use, But Not Regularly
3. _____ Yes, Use Regularly

THE NEXT FEW QUESTIONS ARE ABOUT THE WAYS PEOPLE HANDLE DIFFERENT FEELINGS. CAN YOU CHOOSE ONE OF THE ANSWERS UNDER EACH OF THE QUESTIONS AS WE GO THROUGH THEM? THERE ARE TOO MAY CHOICES FOR ME TO READ OUT LOUD.

NOTE: IF THE RESPONDENT GIVES 2 ANSWERS, RECORD THE FIRST ANSWER AS "1" AND THE SECOND AS "2". CHECK TO SEE THAT THE FIRST ANSWER IS THE PRIMARY ONE AND THE SECOND IS SECOND IN PRIORITY.

10. WHEN YOU GET ANGRY, WHICH OF THE FOLLOWING BEST DESCRIBES WHAT YOU USUALLY DO?

1. _____ Smoke Cigarettes (Or Pipe Or Cigars)
2. _____ Drink
3. _____ Use Drugs
4. _____ Eat
5. _____ Use A Relaxation Technique
6. _____ Listen To TV/Radio Or Music
7. _____ Read
8. _____ Think About The Problem
9. _____ Yell Or Complain
10. _____ Discuss The Problem With Others
11. _____ Something Else (Please Explain) _____

_____

12. _____ Doesn't Apply To Me

11. WHEN YOU FEEL LIKE PEOPLE OR LIFE IS PRESSURING YOU, WHICH OF THE FOLLOWING DO YOU USUALLY DO?

1. _____ Smoke Cigarettes (Or Pipe Or Cigars)
2. _____ Drink
3. _____ Use Drugs
4. _____ Eat
5. _____ Use A Relaxation Technique
6. _____ Listen To TV/Radio Or Music
7. _____ Read
8. _____ Think About The Problem
9. _____ Yell Or Complain
10. _____ Discuss The Problem With Others
11. _____ Something Else (Please Explain) _____

_____

12. _____ Doesn't Apply To Me

12. WHEN YOU FEEL LIKE YOU NEED A DRINK OR SOME DRUGS, WHICH OF THE FOLLOWING DO YOU USUALLY DO?

1. _____ Smoke Cigarettes (Or Pipe Or Cigars)
2. _____ Drink
3. _____ Use Drugs
4. _____ Eat
5. _____ Use A Relaxation Technique
6. _____ Listen To TV/Radio Or Music
7. _____ Read
8. _____ Think About The Problem
9. _____ Yell Or Complain
10. _____ Discuss The Problem With Others
11. _____ Something Else (Please Explain) _____
_____
12. _____ Doesn't Apply To Me

13. WHEN YOU FEEL LIKE LIFE IS UNFAIR TO YOU, WHICH OF THE FOLLOWING DO YOU USUALLY DO?

1. _____ Smoke Cigarettes (Or Pipe Or Cigars)
2. _____ Drink
3. _____ Use Drugs
4. _____ Eat
5. _____ Use A Relaxation Technique
6. _____ Listen To TV/Radio Or Music
7. _____ Read
8. _____ Think About The Problem
9. _____ Yell Or Complain
10. _____ Discuss The Problem With Others
11. _____ Something Else, Please Explain _____
_____
12. _____ Doesn't Apply To Me

14. WHEN YOU FEEL LIKE CELEBRATING A HOLIDAY OR SPECIAL EVENT, WHICH OF THE FOLLOWING DO YOU USUALLY DO?

1. _____ Smoke Cigarettes (Or Pipe Or Cigars)
2. _____ Drink
3. _____ Use Drugs
4. _____ Eat
5. _____ Have Coffee Or Soft Drinks
6. _____ Play A Sport Or Exercise
7. _____ Work At A Hobby Or Project
8. _____ Listen To TV, Radio Or Music
9. _____ Read
10. _____ Socialize With Friends
11. _____ Do Something Risky
12. _____ Other Things, Please Explain _____

_____

13. _____ Does Not Apply To Me

15. WHEN YOU FEEL THAT YOU DESERVE A BREAK FROM HOUSEHOLD CHORES OR HOUSEWORK, WHICH OF THE FOLLOWING DO YOU USUALLY DO?

1. _____ Smoke Cigarettes (Or Pipe Or Cigars)
2. _____ Drink
3. _____ Use Drugs
4. _____ Eat
5. _____ Have Coffee Or Soft Drinks
6. _____ Play A Sport Or Exercise
7. _____ Work At A Hobby Or Project
8. _____ Listen To TV, Radio Or Music
9. _____ Read
10. _____ Socialize With Friends
11. _____ Do Something Risky
12. _____ Other Things (Please Explain _____

_____

13. _____ Does Not Apply To Me

16. WHEN YOU WANT TO RELAX, WHICH OF THE FOLLOWING DO YOU USUALLY DO?

1. _____ Smoke Cigarettes (Or Pipe Or Cigars)
2. _____ Drink
3. _____ Use Drugs
4. _____ Eat
5. _____ Have Coffee Or Soft Drinks
6. _____ Play A Sport Or Exercise
7. _____ Work At A Hobby Or Project
8. _____ Listen To TV, Radio Or Music
9. _____ Read
10. _____ Socialize With Friends
11. _____ Do Something Risky
12. _____ Other Things (Please Explain) _____

_____

13. _____ Does Not Apply To Me

17. WHEN YOU WANT TO FEEL GOOD, WHICH OF THE FOLLOWING DO YOU USUALLY DO?

1. _____ Smoke Cigarettes (Or Pipe Or Cigars)
2. _____ Drink
3. _____ Use Drugs
4. _____ Eat
5. _____ Have Coffee Or Soft Drinks
6. _____ Play A Sport Or Exercise
7. _____ Work At A Hobby Or Project
8. _____ Listen To TV, Radio Or Music
9. _____ Read
10. _____ Socialize With Friends
11. _____ Do Something Risky
12. _____ Other Things, Please Explain _____

_____

13. _____ Does Not Apply To Me

WE ARE GOING TO CHANGE THE SUBJECT A BIT HERE AND ASK YOU TO TELL US A LITTLE ABOUT HOW YOU HAVE BEEN DOING SINCE YOU WERE AT THE WEST END CENTRE.

18. ARE YOU CURRENTLY FREE OF ANY LEGAL PROBLEMS AND COURT SUPERVISION?

1. _____ No Legal Problems - Go To Question 20
2. _____ In Jail
3. _____ On Probation
4. _____ On Parole
5. _____ Awaiting Trial
6. _____ Impaired Driving Charge Or Conviction
7. _____ Other, Please Explain _____

19. (IF ANY LEGAL PROBLEMS) DID ALCOHOL OR DRUGS HAVE ANYTHING TO DO WITH THIS PROBLEM?

1. _____ Yes
2. _____ No

20. HAVE YOU BEEN HOSPITALIZED (EMERGENCY, OUTPATIENT, ETC.), SINCE LEAVING THE WEST END CENTRE? (PROBE TO FIND OUT IF HOSPITALIZATION WAS ALCOHOL OR DRUG-RELATED).

1. _____ Hospitalized For Alcohol/Drugs
2. _____ Hospitalized, But Not For Alcohol/Drugs
3. _____ Not Hospitalized

21. HAVE YOU EXPERIENCED ANY OTHER PROBLEMS INVOLVING ALCOHOL OR DRUGS SINCE YOU WERE AT THE WEST END CENTRE?

1. _____ Yes. Please Explain _____
_____
_____
_____
2. _____ No

22. HAVE YOU HAD ANY ALCOHOLIC DRINKS SINCE YOU WERE AT THE WEST END CENTRE?

1. _____ Yes
2. _____ No

23. DO YOU THINK THAT YOU WILL DRINK ALCOHOL AT SOME TIME IN THE FUTURE?

1. _____ Yes, Certainly
2. _____ Probably
3. _____ Maybe Yes, Maybe No
4. _____ Probably Not
5. _____ Certainly Not

24. HOW DO YOU FEEL ABOUT THAT? _____

Probe: Uses Of Drinking And Substitutes _____

Probe: Relations With Family _____

Probe: Relations With Friends _____

Probe: Meaning Of Not Drinking _____

25. ARE YOU CURRENTLY USING PRESCRIPTION OR OVER-THE-COUNTER DRUGS FOR MEDICAL REASONS?

1. _____ Yes
2. _____ No

26. ARE YOU CURRENTLY USING DRUGS FOR NON-MEDICAL REASONS? (THIS INCLUDES ILLICIT AND LICIT DRUGS).

1. _____ Yes
2. _____ No

27. DO YOU THINK THAT YOU WILL USE MOOD-ALTERING DRUGS (NOT INCLUDING THOSE UNDER A DOCTOR'S PRESCRIPTION OR SUCH THINGS AS VITAMINS, COFFEE OR CIGARETTES), AT SOME TIME IN THE FUTURE?

1. _____ Yes, Certainly
2. _____ Probably
3. _____ Maybe Yes, Maybe No
4. _____ Probably Not
5. _____ Certainly Not

28. HOW DO YOU FEEL ABOUT THAT? _____

Probe: Uses Of Drug Use And Substitutes _____

Probe: Relations With Family _____

Probe: Relations With Friends _____

Probe: Meaning Of Not Taking Drugs _____

29. (IF YES, PROBABLY OR MAYBE ANSWERS TO QUESTION 27, ASK:) WHICH DRUGS DO YOU THINK YOU WOULD USE?

_____

NOW I'D LIKE TO ASK YOU ABOUT YOUR FEELINGS REGARDING THE PROGRAM AT THE WEST END CENTRE.

30. THINK ABOUT THE TIME YOU SPENT AT THE WEST END CENTRE. IS THERE ANY ONE PERSON, OR EXPERIENCE, THAT STANDS IN YOUR MIND? PLEASE EXPLAIN.

_____

_____

_____

_____

_____

31. IN YOUR OPINION, WAS THIS A POSITIVE OR NEGATIVE FACTOR?

1. _____ Negative
2. _____ Positive

TO BE MORE SPECIFIC, I WOULD LIKE YOU TO RATE HOW POSITIVE OR NEGATIVE YOU FOUND EACH OF THE FOLLOWING COMPONENTS OF THE PROGRAM AT THE WEST END CENTRE (IN COPING WITH YOUR ADDICTION).

32. A. GROUP THERAPY

1. _____ Very Negative
2. _____ Somewhat Negative
3. _____ Neutral
4. _____ Somewhat Positive
5. _____ Very Positive
6. _____ Didn't Participate - Go To Question 33

B. WHAT DID YOU FIND MOST HELPFUL? _____

C. WHAT DID YOU FIND LEAST HELPFUL? _____

33. A. INFORMATION LECTURES

1. _____ Very Negative
2. _____ Somewhat Negative
3. _____ Neutral
4. _____ Somewhat Positive
5. _____ Very Positive
6. _____ Didn't Participate - Go To Question 34

B. WHAT DID YOU FIND MOST HELPFUL? _____

C. WHAT DID YOU FIND LEAST HELPFUL? _____

34. A. RECREATION

1. _____ Very Negative
2. _____ Somewhat Negative
3. _____ Neutral
4. _____ Somewhat Positive
5. _____ Very Positive
6. _____ Didn't Participate - Go To Question 35

B. WHAT DID YOU FIND MOST HELPFUL? _____

C. WHAT DID YOU FIND LEAST HELPFUL? _____

35. A. INDIVIDUAL COUNSELLING

1. _____ Very Negative
2. _____ Somewhat Negative
3. _____ Neutral
4. _____ Somewhat Positive
5. _____ Very Positive
6. _____ Didn't Participate - Go To Question 36

B. HOW MANY TIMES DID YOU SEE A COUNSELLOR FOR INDIVIDUAL COUNSELLING _____

C. WHAT DID YOU FIND MOST HELPFUL? _____

D. WHAT DID YOU FIND LEAST HELPFUL? _____

36. A. HAVE YOU ATTENDED THE EVENING FOLLOW-UP PROGRAM SINCE LEAVING THE WEST END CENTRE?

1. _____ Yes
2. _____ No - Go To Question 37

B. EVENING PROGRAM

1. _____ Very Negative
2. _____ Somewhat Negative
3. _____ Neutral
4. _____ Somewhat Positive
5. _____ Very Positive

C. WHAT DID YOU FIND MOST HELPFUL? _____

D. WHAT DID YOU FIND LEAST HELPFUL? _____

SKIP TO QUESTION 38 IF RESPONDENT ATTENDED.

37. WAS THERE ANY REASON YOU COULDN'T ATTEND? _____

_____

PROBE TO FIND OUT WHAT THE WEST END CENTRE COULD CHANGE TO MAKE IT POSSIBLE FOR THE RESPONDENT TO ATTEND. _____

_____

_____

38. RELAXATION THERAPY

1. _____ Very Negative
2. _____ Somewhat Negative
3. _____ Neutral
4. _____ Somewhat Positive
5. _____ Very Positive
6. _____ Didn't Participate - Go To Question 39

B. WHAT DID YOU FIND MOST HELPFUL? _____

C. WHAT DID YOU FIND LEAST HELPFUL? _____

39. WHICH OF THESE COMPONENTS DO YOU FEEL WAS MOST IMPORTANT TO YOU IN COPING WITH YOUR ADDICTION? (CHOOSE ONE).

1. _____ Relaxation Therapy
2. _____ Group Therapy
3. _____ Evening Follow-Up Program
4. _____ Information Lectures
5. _____ Individual Counselling
6. _____ Family Participation
7. _____ Recreation
8. _____ Carry-On Group
9. _____ Other, Please Explain _____
10. _____ None

40. WHICH OF THESE COMPONENTS DO YOU FEEL WAS LEAST IMPORTANT TO YOU IN COPING WITH YOUR ADDICTION? (CHOOSE ONE).

1. _____ Relaxation Therapy
2. _____ Group Therapy
3. _____ Evening Follow-Up Program
4. _____ Information Lectures
5. _____ Individual Counselling
6. _____ Family Participation
7. _____ Recreation
8. _____ Carry-On Group
9. _____ Other, Please Explain _____
10. _____ None

41. PLEASE RATE YOUR CURRENT UNDERSTANDING OF YOUR ALCOHOL/DRUG PROBLEM.

1. _____ Very Poor
2. _____ Poor
3. _____ Fair
4. _____ Good
5. _____ Very Good

42. IS THIS DIFFERENT THAN BEFORE YOU WENT TO THE WEST END CENTRE?

1. _____ Less Understanding Now
2. _____ Unchanged
3. _____ More Understanding Now

Can You Explain That A Bit? _____

_____

43. DID THE STAFF AT THE WEST END CENTRE TRY TO HELP YOU WITH ANY OTHER PROBLEMS IN YOUR LIFE, OR DID THEY WORK ONLY ON ALCOHOL/DRUG PROBLEMS?

1. _____ Worked Only On Alcohol/Drug Problems
2. _____ Worked Only On Other Problems
3. _____ Worked On Both Alcohol/Drug And Other Problems

44. HOW MUCH INDIVIDUAL TREATMENT DID YOU GET AT THE WEST END CENTRE?

1. _____ None
2. _____ Almost None
3. _____ Very Little
4. _____ Some
5. _____ A Great Deal

45. WOULD YOU HAVE PREFERRED MORE OR LESS INDIVIDUAL TREATMENT?

1. _____ Much Less
2. _____ Slightly Less
3. _____ Unchanged
4. _____ Slightly More
5. _____ Much More

46. A. WHEN YOU WERE AT THE WEST END CENTRE, WAS YOUR FAMILY INVOLVED IN THERAPY?

1. _____ Yes
2. _____ No - Go To Part F

B. WHAT KIND OF THERAPY WERE THEY INVOLVED IN?

1. _____ Group Therapy
2. _____ Information Series
3. _____ Individual Counselling
4. _____ Carry-On Group
5. _____ Follow-Up Night
6. _____ Other, Please Explain _____

C. WOULD YOU RATE THAT AS POSITIVE OR NEGATIVE FOR YOU?

1. _____ Very Negative
2. _____ Somewhat Negative
3. _____ Neutral
4. _____ Somewhat Positive
5. _____ Very Positive

D. WHAT DID YOU FIND MOST HELPFUL? _____

E. WHAT DID YOU FIND LEAST HELPFUL? _____

GO TO QUESTION 47

F. WOULD YOU HAVE LIKED THAT TO HAPPEN?

1. _____ Yes
2. _____ No

Can You Explain That A Bit? _____

_____

47. A. SINCE LEAVING THE WEST END CENTRE, HAS YOUR FAMILY BEEN INVOLVED IN THERAPY?

1. _____ Yes
2. _____ No - Go To Part F

B. WHAT KIND OF THERAPY WERE THEY INVOLVED IN?

1. _____ Group Therapy
2. _____ Information Series
3. _____ Individual Counselling
4. _____ Carry-On Group
5. _____ Follow-Up Night
6. _____ Other, Please Explain _____

C. WOULD YOU RATE THAT AS POSITIVE OR NEGATIVE FOR YOU?

1. _____ Very Negative
2. _____ Somewhat Negative
3. _____ Neutral
4. _____ Somewhat Positive
5. _____ Very Positive

D. WHAT DID YOU FIND MOST HELPFUL? _____

E. WHAT DID YOU FIND LEAST HELPFUL? _____

GO TO QUESTION 48

F. WOULD YOU HAVE LIKED THAT TO HAPPEN?

1. _____ Yes
2. _____ No

Can You Explain That A Bit? _____

_____

48. OVERALL, HOW SATISFIED WERE YOU WITH THE TREATMENT YOU RECEIVED FOR YOUR ALCOHOL/DRUG PROBLEM WHILE AT THE WEST END CENTRE?

1. _____ Very Dissatisfied
2. _____ Somewhat Dissatisfied
3. _____ Neutral
4. _____ Somewhat Satisfied
5. _____ Very Satisfied

49. IF THERE WAS ONE THING YOU COULD CHANGE WITH THE PROGRAM AT THE WEST END CENTRE, WHAT WOULD THAT BE? PLEASE EXPLAIN.

_____

_____

_____

_____

_____

50. AT PRESENT, DO YOU FEEL YOU NEED ANY FURTHER HELP OR TREATMENT FOR YOUR ALCOHOL/DRUG PROBLEM?

1. _____ Yes
2. _____ No SKIP TO QUESTION 52
3. _____ Don't Know

51. WHAT KIND OF FURTHER HELP OR TREATMENT DO YOU FEEL YOU NEED?

1. _____ Medication
2. _____ Counselling
3. _____ To See A Psychiatrist
4. _____ Halfway House, Residential Program
5. _____ Hospitalized
6. _____ Further Treatment Not Needed
7. _____ A.A.
8. _____ Other, Please Explain _____
9. _____ Don't Know

52. IF THE NEED AROSE, WOULD YOU RETURN TO THE WEST END CENTRE FOR HELP WITH AN ADDICTION PROBLEM?

1. _____ Yes
2. _____ No
3. _____ Don't Know

53. WOULD YOU ADVISE A FRIEND OR RELATIVE WITH AN ALCOHOL OR DRUG PROBLEM TO GO TO THE WEST END CENTRE FOR HELP?

1. _____ Yes
2. _____ No
3. _____ Don't Know

54. WE'VE COVERED ALL THE MAIN TOPICS IN THE QUESTIONNAIRE. IS THERE ANYTHING THAT YOU WOULD LIKE TO ADD TO YOUR COMMENTS MADE THROUGHOUT THIS INTERVIEW?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

* * * * *

THANK YOU FOR CONTRIBUTING INFORMATION TO THIS STUDY

* * * * *